FNP Clinical Compliance Packet

2017

Email: postlicensurecompliance@chamberlain.edu
chamberlain.edu | 888.556.8CCN (8226)

Please scan and upload your compliance documents using your Chamberlain/American Databank (Complio) account
Dear Chamberlain Student,

On behalf of Chamberlain College of Nursing, I want to extend a personal welcome and wish you great success in your journey toward furthering your career. Our goal is to support your upcoming endeavor by helping facilitate many exciting learning opportunities in various clinical settings that build a solid foundation for you to advance in the profession.

It is extremely important that you familiarize yourself with Chamberlain’s clinical policies and meet all compliance requirements as soon as possible so you won’t face unnecessary obstacles at the time of your practicum. The enclosed information explains the details of all necessary clinical requirements, but I have provided you with the checklist below.

Chamberlain College of Nursing Clinical Program Checklist:

- Health Insurance Requirement
- Clinical Profile
- Student Commitment to Clinical Behaviors
- Clinical Competencies & Functional Abilities
- Personal Health Care Responsibility Letter of Understanding/Confidentiality Statement
- HIPAA Review & Quiz – chamberlain.edu/HIPAA
- OSHA Review & Quiz – chamberlain.edu/OSHA
- Current active RN license – MSN requirement
- Current CPR Certification – BLS for healthcare providers
- Health History & Physical – signed & dated by your physician (must be within one year of practicum)
- Immunization History
  - Measles, Mumps, Rubella titers showing immunity or immunization records of MMR booster
  - Varicella titers showing immunity or immunization records (childhood disease not accepted)
  - Tetanus/Diphtheria/Pertussis Booster (within past 10 years)
  - Annual PPD screening (submit documentation showing test date, date read and result)
  - Hepatitis B series or titer
  - Seasonal Flu Vaccine

These items may be required by your practicum site.

- Background Check
- Drug Screen
- Fingerprint Clearance (as required)
- Family Care Safety Registry (State of Missouri only)
- Hepatitis A Series
- Polio Series

Clinical Compliance Documentation Deadlines:

<table>
<thead>
<tr>
<th>Program</th>
<th>Deadline</th>
<th>Failure to submit documentation will result in the following action</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Programs</td>
<td>30 days before start of practicum course</td>
<td>Clinical Hold - unable to attend site orientation or clinical until appropriate documentation has been received in National Management Office.</td>
</tr>
</tbody>
</table>

Students who are non-compliant in any semester may be denied admission to clinical agencies, resulting in an unsatisfactory clinical grade due to inexcusable absences. This could ultimately result in a student failing a course and/or being dropped from the program.

Original documentation will not be accepted – only clear photocopies. Students are encouraged to keep their original health records and other clinical documents in a safe place in case they are requested for proof by Chamberlain at another time for a specific agency or potential employer.

Please forward all copies to: National Clinical Compliance Office:
3005 Highland Drive, Downers Grove, IL 60515-5799, Fax: 630.596.2374

Please don't hesitate to contact your clinical coordinator if you have any questions, need assistance or just to introduce yourself.

We look forward to working with you!

Kelly Winters
Director, Clinical Shared Services
CLINICAL PROFILE
(TO BE COMPLETED BY STUDENT)

Date: ___________________________ Student ID (D#): ___________________________

Program: ___________________________________________

Name: ___________________________________________

Last First M.I. Maiden/Other

Permanent address:

Street ___________________________ City ___________________________ State Zip

SSN# ___________________________ Date of Birth ______/____/______  □ Male  □ Female

Phone: ___________________________

Home  Cell  Work

Email: ________________________________________________

In case of emergency, contact:

Name: ___________________________________________

Last First Relationship

Address: ___________________________________________

Street ___________________________ City ___________________________ State Zip

Phone: ___________________________

Home  Cell

Primary care physician:

Name: ___________________________ Phone: ___________________________

Address: ___________________________________________

Street ___________________________ City ___________________________ State Zip

Are you currently seeing a physician, psychiatrist or other healthcare provider?  □ Yes  □ No
If yes, explain: ___________________________________________

Please list all current medications you are taking: ___________________________________________

Please list any allergies: ___________________________________________

Are you now or have you been treated for (Please check appropriate boxes):

□ Seizures  □ High Blood Pressure  □ Heart Problems  □ Diabetes
□ Hepatitis (A/B/C)  □ Sickle Cell Anemia  □ Asthma  □ Depression

Other medical problems:

Have you ever been hospitalized?  □ Yes  □ No  Date(s) of hospitalization: ___________________________________________

If yes, please explain: ___________________________________________

Scan and upload your compliance documents to your Chamberlain/Complio account at chamberlainclinicalcompliance.com

Important information about the educational debt, earnings, and completion rates of students who attended this program can be found at chamberlain.edu/gemsn.
STUDENT COMMITMENT TO CLINICAL BEHAVIORS

As a student of Chamberlain College of Nursing, I pledge to abide by all standards of conduct outlined in the academic catalog and student handbook while fulfilling the clinical requirements of the program and commit to the following:

• I understand and agree that as a Chamberlain College of Nursing student I will honor the Code of Professional Conduct as outlined by the National Student Nurses’ Association and I will conduct myself in an ethical manner.
• I pledge to represent myself as a professional by respecting the individuality of my clients/patients, staff, classmates and instructor with dignity.
• I understand that as a guest in each host agency I will abide by the agency’s policy and procedures.
• I will dress professionally and present myself in accordance with the dress code of the College as stated in the student handbook, Dress Regulations/Uniforms.
• I will establish and maintain my compliance with all health and safety requirements as stated in the student handbook.
• I will successfully complete all clinical hours and abide by the attendance policy as stated in the course syllabi.
• I understand it is my responsibility to arrange transportation to and from clinical sites, arrive to my clinical sites approximately 15-30 minutes prior to the scheduled start time of the clinical shift and be prepared to deliver expected nursing care and participate fully in my learning experiences.
• I will notify my clinical instructor of my whereabouts, my schedule and all patient care activities.
• I will actively participate in all aspects of the clinical experiences.
• I understand I am accountable for my personal and professional growth and will remain engaged in all learning opportunities as they support my commitment to achieving academic success.

Student Name: ____________________________________________

Student ID (D#): ____________________________ Program: ____________________________

Student Signature: ____________________________ Date: ____________________________

Competencies and Functional Abilities

Chamberlain College of Nursing recognizes that nursing is an intellectually, mentally and physically demanding profession. Students seeking admission should be aware that they are expected to assimilate basic competencies and abilities throughout their education with or without reasonable accommodation. Competencies and functional abilities required of all nurses are summarized in the table below. If you need accommodations, please contact the Office of Student Disability Services at adaofficer@chamberlain.edu or call 888.556.8226.
## Core Competencies

<table>
<thead>
<tr>
<th>Core Competencies</th>
<th>Standard</th>
<th>Examples (not meant to be inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Thinking and Analytic Thinking</td>
<td>Critical thinking ability that includes the ability to recognize cause/effect and analyze potential solutions</td>
<td>Synthesize knowledge, recognize problems, problem-solve, prioritize, invoke long and short term memory</td>
</tr>
<tr>
<td>Communication and Interpersonal Skills</td>
<td>Convey information orally and in writing using English as the primary language. Demonstrate therapeutic communication and relationship skills.</td>
<td>Write nurses notes, ISBAR, engage in patient conferences, interpret nonverbal cues. Engage in conflict resolution, establish rapport, display non-judgmental attitude.</td>
</tr>
<tr>
<td>Emotional Intelligence</td>
<td>Demonstrate self-awareness, self-management, social awareness and relationship management.</td>
<td>Identify, use, understand, and manage emotions in positive ways to relieve stress. Communicate effectively, empathize with others, overcome challenges, and diffuse conflict.</td>
</tr>
<tr>
<td>Reading</td>
<td>Read, interpret and comprehend all written and electronic materials.</td>
<td>Read and interpret: policies, procedures, progress notes, textbooks, ISBAR, patient paper and electronic charts.</td>
</tr>
<tr>
<td>Mathematical Ability</td>
<td>Demonstrate proficiency in arithmetic functions, measurement and recording devices and reading/recording of numerical information.</td>
<td>Calculate drug dosages, convert to metric system, read monitoring equipment, record numerical assessment/monitoring data.</td>
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</tbody>
</table>

## Functional Abilities

<table>
<thead>
<tr>
<th>Physical Stamina/ Gross Motor Skills/ Mobility</th>
<th>Standard</th>
<th>Examples (not meant to be inclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sight</td>
<td>Distinguish color and visual images within normal range.</td>
<td>Sight: Determine color changes during physical assessment, observe patients in hallways, read computer/monitoring screens.</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hear, with or without aids, voices, sounds and monitoring alarms necessary for safe practice.</td>
<td>Hearing: Monitor blood pressures, hear patients speaking, respond to equipment alarms, auscultate lung sounds.</td>
</tr>
<tr>
<td>Olfactory Sensation</td>
<td>Detect odors, unusual smells or smoke.</td>
<td>Olfactory Sensation: Assess odors during physical assessment, detect odor or smoke.</td>
</tr>
<tr>
<td>Tactile Sensation</td>
<td>Interpret sensations, temperature and environmental temperature.</td>
<td>Tactile Sensation: Perform palpation for monitoring or procedures, respond to environmental temperature changes.</td>
</tr>
<tr>
<td>Physical Health Status</td>
<td>Maintain physical health consistent with employment responsibilities and commitments.</td>
<td>The student will monitor and report own health needs and recognize personal illness and maintain patient safety in transmission of illness. No evidence of fevers over 100°F, body in non-compromised working order (no casts, slings, boots, vomiting, diarrhea, crutches, assistive devices).</td>
</tr>
<tr>
<td>Mental Health Status</td>
<td>Maintain focus and emotional stability in stressful situations and respond to needs of others.</td>
<td>Manage own emotions, respond appropriately in crisis situations, adapt to change readily, maintain therapeutic boundaries.</td>
</tr>
<tr>
<td>Fine Motor / Psychomotor Skills</td>
<td>Perform tasks congruent with nursing roles.</td>
<td>Write legibly, grasp, pick up, manipulate small objects &amp; syringes, calibrate equipment, Perform patient assessment, change dressings, administer injections.</td>
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</tbody>
</table>

To ensure student success in the clinical component of the program, the College must be informed of any change in functional ability. Failure to notify the College may result in failure of the course and/or dismissal from the program.

Student Name: __________________________________________

Student Signature: __________________________________________ Date: __________

Student ID (D#): __________________________________________ Program: ____________________

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PERSONAL HEALTHCARE RESPONSIBILITY
LETTER OF UNDERSTANDING AND
CONFIDENTIALITY STATEMENT

Personal Healthcare
I understand that I am responsible for providing Chamberlain proof of personal health insurance. In the event of my personal illness or injury, I shall assume full responsibility for my personal medical care and treatment and release Chamberlain College of Nursing (“School”) from all responsibility for the provision of such care. If my physician is not accessible, I understand that I may choose to be examined and/or treated by a physician and facility of my choice and will assume full responsibility for any charges accrued and for notifying my physician of such care and treatment. I acknowledge that participation in certain clinical activities involves an inherent risk of injury, and I expressively and unconditionally assume all such risks and dangers, known or unknown, foreseen or unforeseen, relating or incidental to my participation in any such clinical activities. I hereby agree that in consideration of my being permitted to participate in these clinical activities, I hereby release, forever discharge, hold harmless, and indemnify Chamberlain College of Nursing, its members individually, and its parents, subsidiaries, affiliates, officers, shareholders, agents, and employees, of any and from all claims, demands, liabilities, costs, damages, rights and causes of action of whatever kind of nature, arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, death, damage to property, and the consequences thereof, resulting from my participation in or in any way connected with or incidental to the clinical activities.

Providing Patient Care
For and in consideration of being allowed to participate in the clinical experience, the undersigned agrees that if during his/her clinical experience in evaluation and treatment of patients of (“Facility”), the undersigned, on behalf of the undersigned as well as his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the clinical experience program unless such injury or loss arises solely out of School’s or Facility’s gross negligence or willful misconduct.

Confidentiality Statement
The undersigned student of Chamberlain College of Nursing, as a condition of being allowed to participate by Chamberlain in clinical training at any affiliated site (“Facility”) hereby acknowledges and agrees that he/she will keep confidential any information acquired, either written or spoken, while at Facility concerning the patients, staff, students and others at the Facility, all such information to be deemed Personal Health Information (PHI), and will also keep confidential all trade secret and other confidential information of Facility. The undersigned further agrees not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any PHI and further agrees not to reveal to any third party any confidential information of Facility, except as required by law or as authorized by Facility. The undersigned understands that additional penalties for disclosure of PHI may apply as determined by Federal law and regulation.

Medical Records
I authorize the School to require treatment and/or diagnostic testing as a condition of enrollment. I also authorize the School to obtain, review and use the results of my medical records as needed by clinical contracts with clinical sites throughout my student career at Chamberlain College of Nursing.

Dated this _____ day of ______________________________, 20____ Student ID (D#) ______________________________

Program Participant (Print Name)

Program Participant (Signature)
HEALTH HISTORY & PHYSICAL
(TO BE COMPLETED BY A PRIMARY CARE PROVIDER, NP OR PA)

Patient's Information:

Name __________________________ Date of Birth _______ / _______ / _______
Student ID (D#) _________________ Phone ________________________________

Please provide immunization records and/or lab results for the following:

- Seasonal Flu Vaccine
- Annual PPD (completed yearly)
- Measles, Mumps, Rubella
  - MMR Titers results showing Immunity or Adult Booster
- Hepatitis B Titers results showing Immunity or record or series
- Tetanus/Diphtheria/Pertussis (TDAP) booster (within 10 years)
- Varicella
  - Titers results showing Immunity or Adult Booster
    (childhood disease & records will not be accepted)

NOTE: Hepatitis A series, Polio and/or Two-Step PPD may be required of a clinical site

Any physical restrictions or significant abnormalities that would restrict this patient from full participation in the physical activities of this program?

☐ Yes  ☐ No

If yes, explain: __________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

This patient is able to participate in a full program of physical activities except as stated, (if there are no limitations, state NONE): __________

_______________________________________________________________________

Date: _______ / _______ / _______
(mm/dd/yyyy)

Primary Care Provider, NP or PA Signature: ________________________________

Print Name: ________________________________

Last ________________ First ________________

Phone: ________________________________

Address: ________________________________

Street ________________ City ________________ State ________________ Zip ________________

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# SEASONAL FLU REQUIREMENTS FORM

## Patient Information:

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Student ID (D#)</th>
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## Required Vaccine Administration Information:

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Manufacturer Lot #</th>
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<table>
<thead>
<tr>
<th>Vaccine Expiration Date</th>
<th>Site</th>
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<tr>
<th>Date Administered</th>
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<table>
<thead>
<tr>
<th>Administering Immunizer Name &amp; Title (Print)</th>
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<table>
<thead>
<tr>
<th>Administering Immunizer Signature</th>
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