Northeast State Community College Division of Nursing LPN to RN Application

Application Deadline: Monday, March 3, 2014 at 3:00pm

Applicant Name *(Please print)* _____ _____ ____
Last First MI

NeSCC Student ID Number: _____

Street Address: _____ **PO Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Numbers: _____ _____ _____
Home Cell Work/Other

Email Address: _____

Alternative Email Address: _____

**IMPORTANT: If any of the above information changes after submission of your nursing application, please email your new information to nursingmail@NortheastState.edu.*

Please identify the following courses as completed or in progress by placing a check mark in the appropriate column.

Course			Completed	In Progress Spring 2014
BIOL 2010	Anatomy and Physiology I			
BIOL 2020	Anatomy and Physiology II			
ENGL 1010	Composition I			
MATH 1530	Probability and Statistics			
Computer Competency/Proficiency Requirement	INFS 1010: Computer Applications (or) Credit by Examination at Northeast State Community College			
BIOL 1230	Introduction to Microbiology			
PSYC 1030	General Psychology			
SPCH 1010	Fundamentals of Speech Communication			
Humanities/ Fine Arts Elective (One of the options is required for the AAS in nursing degree.)	ARTH 1030: Introduction to Art ARTH 2010: Survey of Art History I ARTH 2020: Survey of Art History II ENGL 2030: Literary Heritage ENGL 2110: American Literature I ENGL 2120: American Literature II ENGL 2130: American Masterpieces ENGL 2180: Myth and Tradition ENGL 2210: English Literature I ENGL 2220: English Literature II ENGL 2330: World Literature	HUM 2010: Introduction to Humanities I HUM 2020: Introduction to Humanities II HUM 2340: Black Studies HUM 2350: Technology in Society MUS 1030: Music Appreciation PHIL 1030: Self and World PHIL 2020: Values and Society PHIL 2210: Intro to the Study of Religion THEA 1030: Introduction to Theatre THEA 2010: Theatre History I THEA 2020: Theatre History II		

College/University Transcripts

All Northeast State Community College Nursing Applicants must submit official (unopened) transcripts with his/her nursing application packet. General course information is provided for each applicant to review prior to making application.

- All courses required for the Associate of Applied Science in Nursing at Northeast State must reflect a grade of a "C" or better or show "in progress".

- Courses, with the grade of "C-", will not be accepted towards the degree.
- If a Course Substitution Form or Petition to Evaluate Transfer Work has been initiated by the applicant, a copy of the initiated form must be included in the Nursing application packet.
- All biology courses (BIOL 2010, BIOL 2020, and BIOL 1230) required for the Associate of Applied Science in Nursing degree must be a total of four (4) credit hours.
- All biology courses (BIOL 2010, BIOL 2020, and BIOL 1230) required for the Associate of Applied Science in Nursing degree must be less than 10 years old at the beginning of the first semester of NURS courses.
- The computer competency/proficiency requirement may be met by the successful completion of INFS 1010 (formerly CSCI 1100): Concepts of Computer Applications or receiving successful Credit by Examination at Northeast State.
    - If INFS 1100 was taken at a different institution, a "C" or better must be reflected as transfer credit on the Northeast State transcript.
    - If INFS 1100 was taken at a different institution, it must be less than 10 years old at the time transcripts were submitted to the Northeast State Admissions and Records Office.
    - If Credit by Exam was taken at a different institution, it will not transfer into Northeast State.
    - If Credit by Exam is taken at Northeast State Community College, it will not transfer to another College/University.
- To check your Northeast State transcript, please go to www.NortheastState.edu and log into MyNortheast. It is the applicant's responsibility to ensure the information posted on official transcripts is correct.

Requirement for Application: Submission of Transcripts

Applicants who have *never attended Northeast State Community College:*

Step #1: Submit official, unopened transcripts from all colleges/universities in which an academic record exists to the Northeast State Admissions and Records Office, 2425 Highway 75, PO Box 246, Blountville, TN 37617-0246.
Step #2: After all college/university official, unopened transcripts have been submitted to the Northeast State Admissions and Records Office and transfer credit is visible on your Northeast State Community College transcript, make a request to the Northeast State Admissions and Records Office for your official, unopened Northeast State Community College transcript to be sent to you.
Step #3: Once you have received the official, unopened Northeast State Community College transcript, place it in the same packet with your nursing application.
Please note: If you are enrolled in class spring 2014, you must submit with your nursing application packet an official, unopened transcript from the institution in which you are enrolled showing spring 2014 classes/s as "in progress".

Applicants who have *attended Northeast State Community College and other colleges and/or universities*:

Step #1: Submit official, unopened transcripts from all colleges/universities in which an academic record exists to the Northeast State Admissions and Records Office, 2425 Highway 75, PO Box 246, Blountville, TN 37617-0246.
Step #2: After all college/university official, unopened transcripts have been submitted to the Northeast State Admissions and Records Office and transfer credit is visible on your Northeast State Community College transcript, make a request to the Northeast State Admissions and Records Office for your official, unopened Northeast State Community College transcript to be sent to you.
Step #3: Once you have received the official, unopened Northeast State Community College transcript, place it in the same packet with your nursing application.
Please note: If you are enrolled in class spring 2014, you must submit with your nursing application packet an official, unopened transcript from the institution in which you are enrolled showing spring 2014 classes/s as "in progress".

Applicants who have *only attended Northeast State Community College:*

Step #1: Make a request to the Northeast State Admissions and Records Office for your official, unopened Northeast State Community College transcript to be sent to you.
Step #2: Once you have received the official, unopened Northeast State Community College transcript, place it in the same packet with your nursing application.
Please note: If you are enrolled in class spring 2014, you must submit with your nursing application packet an official, unopened transcript from the institution in which you are enrolled showing spring 2014 classes/s as "in progress".

Important Information Regarding Summer 2014 Registration for Applicants Accepted into the LPN to RN Program

- If you are accepted into the program, the nursing secretary or a designee of the Nursing division will register you for NURS 1050: Nursing Transitions, which consists of ten (10) credit hours and composed of three components (lecture, lab, and clinical). Student schedules will be assigned by the Dean of Nursing.
- Accepted Students, who have not completed BIOL 1230: Introduction to Microbiology and PSYC 1030: General Psychology, will need to register for these courses to be completed during the summer 2014 as they are required to be completed prior to or during the summer semester of the LPN to RN program.
- Accepted Students, who wish to be considered full-time for scholarship, insurance or financial aid reasons, will need to register for addition needed credit hours; if you are uncertain if this applies to you, contact financial aid for more information.

Application Deadline: Monday, March 3, 2014 at 3:00pm

Have you ever applied to the Northeast State Nursing Program before this application? YES ☐ NO ☐
If you answer "yes", please answer questions 1 and 2 below.

1. What year/s did you previously apply to the Nursing Program? Summer _____.

2. If you have previously applied to the Nursing Program, were you accepted? YES ☐ NO ☐ If you marked "yes", please answer question "a".
   a. Were you registered for a nursing (NURS) course? YES ☐ NO ☐ If you marked "yes", please answer i-iii below.
      i. Circle the course/courses you were registered and circle the outcome of each.

Course	Circle the outcome of the course.			
NURS 1100	Audit	Withdrawal	Failure	Successfully passed
NURS 1200	Audit	Withdrawal	Failure	Successfully passed
NURS 2000	Audit	Withdrawal	Failure	Successfully passed
NURS 2200	Audit	Withdrawal	Failure	Successfully passed
NURS 2400	Audit	Withdrawal	Failure	Successfully passed
NURS 2600	Audit	Withdrawal	Failure	Successfully passed

      ii. Did you complete an Exit Interview? YES ☐ NO ☐
      If you marked no, complete the Exit Interview form located in your *Nursing Student Handbook*, and place in your nursing application packet. If you cannot locate the form, contact the Nursing Division at 423.354.5108.
      iii. Did you submit a written request for re-entry to the Dean of Nursing? YES ☐ NO ☐
      If you marked no, complete a written request stating the reasons for previous academic non-progression and provide a description of actions that will be taken to enhance success if the opportunity for readmission were to be granted, and place in your nursing application packet.

Prior Application to Northeast State Associate of Applied Science in Nursing Program
If you have made application to the Northeast State Associate of Applied Science in Nursing program in prior years and wish to be considered for application for this cycle, you must reapply, completing all application requirements again, as if this were your first time applying.

Prior Acceptance and Admission to Northeast State Associate of Applied Science in Nursing Program
For applicants, who have previously been accepted into the Northeast State Nursing Program and were enrolled in one or more of the NURS courses, you must print and complete the nursing application meeting all deadlines. All requirements for application are applicable to all students seeking readmission. Nursing students are allowed one readmission.

Clinical Health Care Requirements
All accepted nursing students must comply with the health care agencies' clinical requirements. Clinical requirements are enforced by clinical affiliates and OSHA regulations. Please be aware that clinical affiliates may refuse clinical rotation access to students who fail to obtain the required immunizations, therefore, negatively impacting a student's ability to successfully progress in the curriculum/program. Clinical requirements may be added or changed based on current information regarding communicable diseases and/or revisions/additions of new College, Board of Regents, and/or health care agency requirements. Students will be informed of new requirements and deadlines for new requirements.

Currently, all accepted nursing students are required to submit to the Northeast State Nursing Division documentation of completed vaccination/immunization series or positive titers for the following:

Measles, Mumps, Rubella (MMR)
Varicella
Hepatitis B
Tuberculosis (Tb) Screen
Tetanus, Diphtheria and Pertussis (TDaP)
Influenza

In addition, all accepted nursing students are required to submit to the Northeast State Nursing Division documentation of other clinical health care agency requirements including Health Verification, Medical Physical Exam, Confidentiality Agreement, Background Check, CPR for health care personnel, OSHA, HiPPA, and Malpractice Insurance. The Nursing Division also requires students to read and agree to abide by the Ethical and Professional Behavior Agreement, Student Confidentiality Agreement, Tennessee Professional Assistance Program, Drug and Alcohol Testing Consent, and Core Performance Standards.

Clinical Health Care Requirement Exemptions
Valid exemptions include medical exemption and/or a religious exemption. Medical Exemption: Physician, health department, or health care provider provides documentation indicating medical exemption from specific vaccinations due to risk of harm stating one of the following as a contraindication for

the vaccination: (1) the individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; (2) the individual meets the criteria for contraindication published by the U.S. Centers for Disease Control of the ACIP; or (3) in the best professional judgment of the health care provider, based on the individual's medical condition and history, the risk of harm from the vaccinate outweighs the potential benefit. Religious Exemption: The student's religious affiliate provides on official letterhead a signed, notarized statement (affirmed under penalties of perjury) indicating the vaccination conflicts with the student's religious tenets or practices.

Requirement for Application: Submission of Clinical Health Care Requirements
All Nursing Applicants are required to provide proof of the first and second hepatitis B immunizations, positive titer, or documentation supporting one or more of the exemptions listed above with the nursing application packet. Twinrix ® is also acceptable to meet the hepatitis B vaccine requirement, and the dosing schedule for this vaccine must follow CDC guidelines (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5640a5.htm). The immunization series must be started in a timely manner so the series can be completed by the deadline established within the Nursing Division. If dose three cannot be completed by this date, students may not attend clinical until all requirements have been satisfied.

The Nursing Division establishes deadlines for submission of all documentation. Noncompliance with deadlines (incomplete clinical health care requirements) leads to the student's inability to be assigned to a clinical facility, thus leading to the inability to enter and/or complete the clinical component of the nursing course.

Nursing Applicants are to submit copies of all clinical healthcare requirement documentation with their LPN to RN application packet. Do not send original documents. The applicant's name is required to be on the proof of documentation. If a health care provider's statement is used, the applicant's name and the health care provider's signature are required on the documentation. Please ensure Exhibits A – F at the end of the application are also completed and included with your application packet.

Healthcare Personnel Vaccination Recommendations[1]

Vaccine	Recommendations in brief
Hepatitis B	Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Give IM. Obtain anti- HBs serologic testing 1–2 months after dose #3.
Influenza	Give 1 dose of influenza vaccine annually. Give inactivated injectable vaccine intramuscularly or live attenu- ated influenza vaccine (LAIV) intranasally.
MMR	For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give SC.
Varicella (chickenpox)	For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart. Give SC.
Tetanus, diphtheria, pertussis	Give a dose of Tdap as soon as feasible to all HCP who have not received Tdap previously and to pregnant HCP with each pregnancy (see below). Give Td boosters every 10 years thereafter. Give IM.
Meningococcal	Give 1 dose to microbiologists who are routinely exposed to isolates of *N. meningitidis* and boost every 5 years if risk continues. Give MCV4 IM; if necessary to use MPSV4, give SC.

Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material.

Hepatitis B

Healthcare personnel (HCP) who perform tasks that may involve exposure to blood or body fluids should receive a 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Test for hepatitis B surface antibody (anti-HBs) to document immunity 1–2 months after dose #3.

- If anti-HBs is at least 10 mIU/mL (positive), the patient is immune. No further serologic testing or vaccination is recommended.
- If anti-HBs is less than 10 mIU/mL (negative), the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series. Retest anti-HBs 1–2 months after dose #3.

- If anti-HBs is positive, the patient is immune. No further testing or vaccination is recommended.
- If anti-HBs is negative after 6 doses of vaccine, patient is a non-responder. For non-responders: HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood.[1] It is also possible that non-responders are people who are HBsAg positive. Testing should be considered. HCP found to be HBsAg positive should be counseled and medically evaluated.

Note: Anti-HBs testing is not recommended routinely for previously vaccinated HCP who were not tested 1–2 months after their original vaccine series. These HCP should be tested for anti-HBs when they have an exposure to blood or body fluids. If found to be anti-HBs negative, the HCP should be treated as if susceptible.[2]

Influenza

All HCP, including physicians, nurses, paramedics, emergency medical technicians, employees of nursing homes and chronic care facilities, students in these professions, and volunteers, should receive annual vaccination against influenza. Live attenuated influenza vaccine (LAIV) may be given only to non-pregnant healthy HCP age 49 years and younger. Inactivated injectable influenza vaccine (IIV) is preferred over LAIV for HCP who are in close contact with severely immunosuppressed people (e.g., stem cell transplant patients) when patients require protective isolation.

Measles, Mumps, Rubella (MMR)

HCP who work in medical facilities should be immune to measles, mumps, and rubella.

- HCP born in 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) laboratory confirmation of disease or immunity or (b) appropriate vaccination against measles, mumps, and rubella (i.e., 2 doses of live measles and mumps vaccines given on or after the first birthday and separated by 28 days or more, and at least 1 dose of live rubella vaccine). HCP with 2 documented doses of MMR are not recommended to be serologically tested for immunity; but if they are tested and results are negative or equivocal for measles, mumps, and/or rubella, these HCP should be considered to have presumptive evidence of immunity to measles, mumps, and/or rubella and are not in need of additional MMR doses.
- Although birth before 1957 generally is considered acceptable evidence of measles, mumps, and rubella immunity, healthcare facilities should consider recommending 2 doses of MMR vaccine routinely to unvaccinated HCP born before 1957 who do not have laboratory evidence of disease or immunity to measles and/or mumps, and should consider 1 dose of MMR for HCP with no laboratory evidence of disease or immunity to rubella. For these same HCP who do not have evidence of immunity, healthcare facilities should recommend 2 doses of MMR vaccine during an outbreak of measles or mumps and 1 dose during an outbreak of rubella.

Varicella

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart, history of varicella or herpes zoster based on physician diagnosis, laboratory evidence of immunity, or laboratory confirmation of disease.

Tetanus/Diphtheria/Pertussis (Td/Tdap)

All HCPs who have not or are unsure if they have previously received a dose of Tdap should receive a dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Pregnant HCP need to get repeat doses during each pregnancy. All HCPs should then receive Td boosters every 10 years thereafter.

Meningococcal

Vaccination with MCV4 is recommended for microbiologists who are routinely exposed to isolates of *N. meningitidis.* Use MPSV4 only if there is a permanent contraindication or precaution to MCV4.

References

_____

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

1. CDC. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR,* 2011; 60(RR-7).
2. See Table 3 in Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post exposure Prophylaxis, *MMWR*, 2001; 50(RR-11).

For additional specific ACIP recommendations, refer to the official ACIP statements published in *MMWR*. To obtain copies, visit CDC's website at www.cdc.gov/vaccines/ pubs/ACIP-list.htm; or visit the Immunization Action Coalition (IAC) website at www. immunize.org/acip.

Technical content reviewed by the Centers for Disease Control and Prevention

ImmunizationActionCoalition 1573SelbyAvenue • St.Paul,MN55104 • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Application Requirement: Clinical Health Care Requirement Health Verification NSCC-3 09-037

In case of emergency notify the person below:

Name: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Relationship: _____

Past/Chronic Medical Problems/ Injuries:_____

Hospitalizations: _____

Medications Currently Taking (Prescription, Herbal, Over the Counter): _____

Are you currently under treatment for any medical conditions? Yes No If Yes, please explain._____

List emotional or chemical dependency problems and treatment for such (include present and past problems and treatment).

_____

Allergies (include medications and other substances):

_____

If you have had any of the following please circle and include dates and explanation:

Condition	Date/Explanation	Condition	Date/Explanation
Allergies		Kidney Disease	
Anemia		Liver Disease	
Asthma/Respiratory Problems		Rheumatoid Arthritis	
Birth Defects		Rheumatic Fever	
Bowel Problems		Seizures	
Cancer		Thyroid Disease	
Diabetes		Tuberculosis	
Emphysema		Surgeries	
Hearing Problems		Injuries (including back)	
Heart Disease		Activity Restrictions	
High Blood Pressure		Neurological Disorders	
Hepatitis		Ulcers (Duodenal or Peptic)	
Hernias		Visual Problems	
High Cholesterol or Lipids		Emotional Problems	

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Application Requirement: Health Verification by Physician, Nurse Practitioner, or Physician Assistant Report *(To be completed by a physician, nurse practitioner, or physician assistant.)*

Student Applicant _____ Student ID# _____
(Last, First, Middle)

Height_____ Weight_____ Pulse_____ B/P_____ R/R_____

Eyes without glasses: Right 20/___Left 20/___ Eyes with glasses: Right 20/___Left 20/___

Near Vision: _____ Color Perception: Right_____ Left_____

Hearing: Right _____ Left _____

Check if Normal:		Comments:
_____	General Appearance	_____
_____	Head & Scalp	_____
_____	Face & Skin	_____
_____	E.E.N.T.	_____
_____	Neck	_____
_____	Heart	_____
_____	Lungs	_____
_____	Breast	_____
_____	Abdomen	_____
_____	Back & Spine	_____
_____	Extremities	_____
_____	Lymphatic	_____
_____	Neurological	_____
_____	Genitourinary	_____

Current Medications:
_____

Is student able to perform all duties expected of a health care provider?

☐ Yes, the student is able to perform all duties expected of a health care provider without restrictions

☐ Yes, the student is able to perform duties expected of a health care provider with the following restrictions:
_____

☐ No, the student is not able to perform duties expected of a health care provider.

Name of Healthcare Provider: _____
Address: _____
Phone: _____

_____ _____
Physician, Nurse Practitioner, or Physician Assistant's Signature Date NSCC-3 09-034

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Basic Life Support for Healthcare Providers

All students must maintain current CPR certification throughout the nursing program to participate in hospital clinical practice. Students may not participate in clinical practice unless this information is on file. American Heart Association CPR is required for healthcare providers.

Community CPR does not meet the requirement.
Internet CPR courses do not meet the requirement.

Attach a copy of both the front and back of your current CPR certification card to the back of this page.

Measles, Mumps, Rubella (MMR)

Student Name (Printed):_____Student ID Number: _____

Student Signature: _____Date: _____

By my signature above, I acknowledge that I have received and read the information provided regarding the MMR vaccination. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provider.

Information about MMR vaccination from CDC:
http://www.cdc.gov/vaccines/schedules/downloads/adult/mmwr-adult-schedule.pdf

Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of one or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. **For rubella**, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

Measles Component: A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with two doses of MMR vaccine.
Mumps Component: A second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who 1) live in a community experiencing a mumps outbreak and are in an affected age group; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g. persons who are working in a health-care facility) should be revaccinated with two doses of MMR vaccine.
Rubella Component: For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.
Health-care Personnel Born Before 1957: For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should 1) consider routinely vaccinating personnel with two doses of MMR vaccine at the appropriate interval (for measles and mumps) and 1 dose of MMR vaccine (for rubella), and 2) recommend two doses of MMR vaccine at the appropriate interval during an outbreak of measles or mumps, and one dose during an outbreak of rubella. Complete information about evidence of immunity is available at http://www.cdc.gov/vaccines/pubs/pinkbook/meas.html.

Medical Exemption: Physician, health department, or health care provider provides documentation indicating medical exemption from specific vaccinations due to risk of harm stating one of the following as a contraindication for the vaccination: (1) the individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; (2) the individual meets the criteria for contraindication published by the U.S. Centers for Disease Control of the ACIP; or (3) in the best professional judgment of the health care provider, based on the individual's medical condition and history, the risk of harm from the vaccinate outweighs the potential benefit.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Religious Exemption: The student's religious affiliate provides on official letterhead a signed, notarized statement (affirmed under penalties of perjury) indicating the vaccination conflicts with the student's religious tenets or practices.

Decide which box applies to you and place an "X" in the box you selected. You must supply additional documentation if selected box requests such.
□ I have had two doses of measles, mumps, rubella vaccination (No earlier than 4 days before 1st birthday, ≥ 28 days apart). (Must provide documentation of proof of first and second doses of the MMR vaccination; may copy and attach to back of this form.)
□ I was born before 1957 and have a positive titer for measles, mumps, and rubella with IgG positive or immune. (Must provide documentation of positive titer for measles, mumps, and rubella; may copy and attach to back of this form.)□ I was born in or after 1957 and have a positive titer for measles, mumps, rubella, and rubeola with IgG positive or immune. (Must provide documentation of positive titer for measles, mumps, and rubella; may copy and attach to back of this form.)
□ I met one of the approved exemptions and have provided the appropriate documentation.

Varicella (Chicken Pox)
Student Name (Printed):_____Student ID Number: _____
Student Signature: _____Date: _____
By my signature above, I acknowledge that I have received and read the information provided regarding the varicella vaccination. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provider.

Information about Varicella vaccination from CDC:
http://www.cdc.gov/vaccines/schedules/downloads/adult/mmwr-adult-schedule.pdf
All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or a second dose if they have received only 1 dose, unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child-care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or having an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.

Medical Exemption: Physician, health department, or health care provider provides documentation indicating medical exemption from specific vaccinations due to risk of harm stating one of the following as a contraindication for the vaccination: (1) the individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; (2) the individual meets the criteria for contraindication published by the U.S. Centers for Disease Control of the ACIP; or (3) in the best professional judgment of the health care provider, based on the individual's medical condition and history, the risk of harm from the vaccinate outweighs the potential benefit.
Religious Exemption: The student's religious affiliate provides on official letterhead a signed, notarized statement (affirmed under penalties of perjury) indicating the vaccination conflicts with the student's religious tenets or practices.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Decide which box applies to you and place an "X" in the box you selected. You must supply additional documentation if selected box requests such.

□ I was born before 1980, therefore presumed immune through past illness; or

□ My healthcare provider believes I have had the chickenpox. (Must supply signed documentation from healthcare provider with year of illness; may copy and attach to the back of this form); or

□ I have had two doses of varicella vaccine (No earlier than 4 days before 1st birthday, ≥ 28 days apart). (Must provide documentation of proof of first and second doses of the Varicella vaccination; may copy and attach to the back of this form); or

□ I have a positive titer for Varicella with IgG positive or immune. (Must provide documentation of positive titer for varicella; may copy and attach to the back of this form); or

□ I met one of the approved exemptions and have provided appropriate documentation.

Hepatitis B Immunization

Student Name (Printed):_____Student ID Number: _____

Student Signature: _____Date: _____

By my signature above, I acknowledge that I have received and read the information provided regarding the Hepatitis B immunization. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provider.

Information about Hepatitis B Immunization from CDC:
http://www.cdc.gov/vaccines/schedules/downloads/adult/mmwr-adult-schedule.pdf

Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:

Behavioral: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous six months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men.

Occupational: Health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Medical: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

Other: Household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at http://www.cdc.gov/travel/yellowbook/2012/chapter-3-infectious-diseases-related-to-travel/hepatitis-b.htm).

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential day-care facilities for persons with developmental disabilities.

Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21 to 30, followed by a booster dose at month 12, may be used.

Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 μg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 μg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Effective July 1, 2011, unless exempted by law, any student enrolled in a higher education institution who is a health science student expected to have patient contact shall present proof of protection against hepatitis B before patient contact begins. For purposes of this paragraph adequate immunization is defined as:

1. A complete hepatitis B vaccination series (attach a copy of immunization record showing completed series or a statement of immunization dates on prescription pad with physician, advanced practice nurse, or physician assistant's signature, date, and DEA number in the box provided), *or*
2. Laboratory evidence of immunity via a HB Titer (attach a copy of blood test results showing immunity in the box provided).

If proof of a completed series – injections 1, 2, and 3; positive or immune titer; medical exemption; or religious exemption was submitted with nursing application packet, no other form of documentation needed. If proof of injection #1 and #2 was provided with nursing application, supply proof of injection #3.

Medical Exemption: Physician, health department, or health care provider provides documentation indicating medical exemption from specific vaccinations due to risk of harm stating one of the following as a contraindication for the vaccination: (1) the individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; (2) the individual meets the criteria for contraindication published by the U.S. Centers for Disease Control of the ACIP; or (3) in the best professional judgment of the health care provider, based on the individual's medical condition and history, the risk of harm from the vaccinate outweighs the potential benefit.
Religious Exemption: The student's religious affiliate provides on official letterhead a signed, notarized statement (affirmed under penalties of perjury) indicating the vaccination conflicts with the student's religious tenets or practices.

Decide which box applies to you and place an "X" in the box you selected. You must supply additional documentation if selected box requests such.
□ I have had three doses of Hep B vaccination, and provided documentation of all three doses with my nursing application.
□ I have completed this series since making application to the nursing program and have attached proof of completion of series to the back of this form.
□ I have a positive or immune titer for Hepatitis B and have attached this documentation to the back of this form.
□ I met one of the exemptions and have provided the appropriate documentation.

Tuberculosis (Tb) Screening
Student Name (Printed):_____Student ID Number: _____
Student Signature: _____Date: _____
By my signature above, I acknowledge that I have received and read the information provided regarding the Tb screening. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provider.

Information about Tuberculosis (Tb) *from CDC and NIOSH:*
http://www.cdc.gov/niosh/topics/tb/
Transmission of tuberculosis (TB) is a recognized risk to patients and healthcare workers in healthcare settings. Transmission is most likely to occur from patients who have unrecognized TB or have received ineffective treatment. Workers in correctional and detention facilities are also at risk when exposed to prisoners with active TB disease.

TB is a contagious and potentially life-threatening infectious disease caused by a bacterium called Mycobacterium tuberculosis. The TB bacteria are spread from person to person through the air. People with TB disease of the lungs or larynx release the bacteria into the surrounding area when they cough, sneeze, talk, or otherwise expel air, dispersing droplets that contain M. tuberculosis. These droplets can dry into tiny particles called droplet nuclei that remain suspended in air for long periods of time. Other people can breathe the infectious particles into their lungs and become infected. Infection usually requires prolonged sharing of airspace with a person actively spreading TB bacteria into the area. In rare cases, TB infection has been documented after short exposures to such persons with active TB. After becoming infected, most people's immune systems are able to contain the infection, but are not able to eliminate it without help from anti-TB drugs. These people have latent TB infection and remain infected until corrective treatment is completed. Latent TB

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

infection does not cause symptoms and is not contagious. However, without treatment, infected people can lose control of the infection and develop active, clinical disease. People with active TB have symptoms and can spread the disease. The risk of developing active TB disease is greatest in the first few years after infection, but some risk remains throughout life.

TB is preventable and, in most cases, treatable. Infection control practices can help reduce the risk of TB transmission. Treatment of persons with latent TB infection can prevent the subsequent development of active TB, and TB disease can usually be cured by available anti-TB drugs. Even persons with drug-resistant strains can often be cured by alternative regimens of medications.
Effective infection-control practices are critical to prevent the transmission and further spread of in health-care settings and other congregate settings. CDC has established infection-control guidelines which were updated in December 2005 and should continue to be updated as needed.

□ I have completed the Tb Screening Tool for Healthcare Workers and have no high risk symptoms or history responses. If any of the responses change, I will notify my NESCC clinical faculty and obtain a Tb Skin Test.
□ I have completed the Tb Screening Tool for Healthcare Workers and have high risk symptoms or history responses and have completed the requirement of a chest X-Ray as documented in the following box.
□ I have had a positive skin test and have completed the requirement of a chest X-Ray as documented in the following box.

Date of Chest X-Ray _____Results _____(Attach Documentation)

Information of Licensed Healthcare Provider

Name:_____

Address: _____

Phone: _____

*Healthcare Provider's Signature*_____

Influenza Vaccine
Student Name (Printed):_____Student ID Number: _____
Student Signature: _____Date: _____
By my signature above, I acknowledge that I have received and read the information provided regarding the Influenza Vaccination. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provide.

Information about Influenza from CDC:
http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf
Annual vaccination against influenza is recommended for all persons aged six months and older, including all adults. Healthy, nonpregnant adults aged less than 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (FluMist), or inactivated vaccine. Other persons should receive the inactivated vaccine. Adults aged 65 years and older can receive the standard influenza vaccine or the high-dose (Fluzone) influenza vaccine. Additional information about influenza vaccination is available at http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

□ I have received the influenza vaccination and supplied documentation from my provider indicative of this fact with the date vaccination was administered. A copy of my documentation has been attached to the back of this form.
□ I have also completed the Influenza Compliance Form.
□ I met one of the exemptions and have provided the appropriate documentation.

Tdap
Student Name (Printed):_____Student ID Number: _____
Student Signature: _____Date: _____
By my signature above, I acknowledge that I have received and read the information provided regarding the Tdap immunization. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from my healthcare provider.

Information about Tdap Immunization from CDC:
http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf

Administer a one-time dose of Tdap to adults aged less than 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters, and as soon as feasible to all 1) postpartum women, 2) close contacts of infants younger than age 12 months (e.g., grandparents and child-care providers), and 3) healthcare personnel with direct patient contact. Adults aged 65 years and older who have not previously received Tdap and who have close contact with an infant aged less than 12 months also should be vaccinated. Other adults aged 65 years and older may receive Tdap. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-containing vaccine.

Adults with uncertain or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses. Substitute a one-time dose of Tdap for one of the doses of Td, either in the primary series or for the routine booster, whichever comes first.

If a woman is pregnant and received the most recent Td vaccination 10 or more years previously, administer Td during the second or third trimester. If the woman received the most recent Td vaccination less than 10 years previously, administer Tdap during the immediate postpartum period. At the clinician's discretion, Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap may be administered instead of Td to a pregnant woman after an informed discussion with the woman.

The ACIP statement for administering Td as prophylaxis in wound management is available at
http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/tetanus.pdf

Note: The Td/Tdap vaccination footnote (#2) has language added to indicate that persons aged 65 years and older who have close contact with an infant aged less than 12 months should get vaccinated with Tdap; the additional language notes that all persons aged 65 years and older may get vaccinated with Tdap. Also added is the recommendation to administer Tdap regardless of interval since the most recent Td-containing vaccine.

To reduce pertussis morbidity among adults, maintain the standard of care for tetanus and diphtheria prevention, and to reduce the retransmission of pertussis to infants and in health-care settings, the Advisory Committee on Immunization Practices recommends that health-care professional who work in hospitals or ambulatory care settings and have direct patient contact should receive a single dose of Td as soon as feasible if they have not previously received Tdap.

Tdap immunization or a Td booster immunization must be documented within the last 10 years.

□ I received Tdap vaccination on _____/_____/_____(month/date/year) and have attached documentation.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

□ It has been 10 years or more since my Tdap was administered and have received a Td booster. Documentation of Td booster is attached.
□ I meet one of the approved exemptions and have provided the appropriate documentation.

Varicella Immunization Form For Contract/Student Personnel
_____ I have had Chicken Pox

_____ To my knowledge, I have not had Chicken Pox. I have been informed that a Titer can be done to determine my immunity. I understand that I can have this Titer at my expense. I also understand that should the Titer indicate that I am non-immune to varicella (the virus that causes Chicken Pox), it is recommended that I obtain the varicella immunization, also at my expense. I wish to obtain the Titer and if necessary, the vaccine and will provide proof of these prior to work.

_____ To my knowledge, I have not had Chicken Pox, I have been informed that a Titer can be done to determine my immunity. I understand that I can have this Titer at my expense. I also understand that should the Titer indicate that I am non-immune to varicella (the virus that causes Chicken Pox), it is recommended that I obtain the varicella immunization, also at my expense. At this time, I choose not to receive the Titer to determine my immunity, and I should be aware that I may not be immune and that:

1. I may contract varicella as result of this assignment, (by exposure to Chicken Pox of shingles)
2. If I am pregnant and contract varicella, this may result in serious consequences for both the mother and fetus;
3. Should I contract varicella, I may carry the illness to patients, employees, or persons in the community including my family and friends;
4. If I am exposed to varicella virus (Chicken Pox or shingles), I am to notify Employee Health and my employer/school immediately. I will be relieved from duty from day 10-21 post exposure.

However, I also understand that by signing this form today does not prohibit me from obtaining the Titer and vaccine at a later date.

By signing this form, I am acknowledging that I have read the information on this form and if I have indicated that I have not had chicken pox, I understand the risks associated with not having the Titer and if necessary, the varicella vaccine.

_____ _____
Print Name Signature of Student

_____
Name of Contracting Agency or School

_____
Witness Date

Nursing Student Ethical and Professional Behavior
Student Code of Ethics

Nursing Students are expected to conform to the American Nurses Association's Code of Ethics listed below. In addition, all students are expected to be honest and honorable in all academic and professional endeavors. It is also expected that they refrain from activity that may impair the image of the College, the Nursing Program, or the profession of nursing.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

American Nurses Association Code of Ethics

- The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.
- The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical or illegal practice of any person.
- The nurse assumes responsibility and accountability for individual nursing judgments and actions.
- The nurse maintains competence in nursing.
- The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities to others.
- The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.
- The nurse participates in the profession's efforts to implement and improve standards of nursing.
- The nurse participates in the profession's effort to establish and maintain conditions of employment conducive to high quality nursing care.
- The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.
- The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

Academic Integrity

Northeast State Nursing Program is committed to integrity in the academic setting. Plagiarism, cheating, and other forms of academic dishonesty are prohibited. Students guilty of an academic integrity violation, either directly or indirectly through participation or assistance, are initially responsible to the instructor of the class. The instructor has the authority to assign a zero for an exercise or examination or assign an "F" as the course grade. In addition to action by the instructor, the student may be subject to additional disciplinary action that may be imposed through the institution. All school related work shall be done individually. This includes any assignments, graded work, or clinical preparations.

Specifically, nursing students shall not:

- Commit plagiarism.
- Submit another individual's work in whole or part as one's own.
- Provide assignments for another student to copy.
- Copy answers from another individual.
- Conceal information during an examination/test/quiz which can be used to answer questions.
- Pass on information about examination/test/quiz to others.
- Submit prior work from previously attempted semesters as original work when reentering the program.

Other forms of dishonesty, including but not limited to breaches of confidentiality or falsification of records, will not be tolerated and will be considered violating academic integrity policy.

Academic Misconduct

Academic Misconduct includes but is not limited to plagiarism, falsification of documents such as assignments or materials, cheating, and the giving and/or receiving of unauthorized assistance on tests, examinations, or other assignments. Other forms of dishonesty will not be tolerated. This may include, but is not limited to, breaches in confidentiality and falsification of records.

Professional Misconduct

Professional Misconduct is a violation of any of the following:

- Not acting responsibly in practice environments.
- Not obtaining consultation when uncertain circumstances are present.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

- Not maintaining competence.

A student who is a licensed health professional and has their license suspended and/or revoked must notify the dean of Nursing immediately. Failure to provide notification may result in the inability to progress in the program. Each case will be reviewed by the dean of Nursing on an individual basis. A student guilty of not abiding by the Student Code of Ethics, the American Nurses Association Code of Ethics, or participating in academic or professional misconduct, either directly or indirectly through participation or assistance, is initially responsible to the instructor of the class. The instructor has the authority to assign a zero for an exercise or examination or assign an "F" as the course grade. In addition to action by the instructor, the student may be subject to additional disciplinary action that may be imposed through the institution. Nursing students sign the "Nursing Student Ethical and Professional Behavior" form indicating that they have read, understand, and agree to abide by the Student Code of Ethics throughout the enrollment of the Nursing program.

Student's Printed Name: _____

Student's Signature: _____

Date: _____

Student Confidentiality Agreement

It is the policy of Northeast State Community College Nursing Program to maintain the confidentiality of all clients in the health care setting. As a nursing student at Northeast State Community College, I understand that I may have access to and be involved in the processing of confidential client information. I agree that I will only access client information if I have a medical "need to know". I understand that such information must be maintained in the strictest confidence while I am in the client-care environment and also after I am outside the client-care environment.

As a nursing student at Northeast State Community College, I agree not to disclose any confidential information to any person whatsoever or permit any person whatsoever to examine or make copies of any confidential reports, records, or documents prepared by me, coming into my possession, or under my control, or use confidential information other than as necessary in the course of my clinical assignment. In instances when I have computer access, I will keep my user identification code and my password secure understanding that it is the legal equivalent of my signature. I understand that sharing confidential client information or implementing actions which place confidential client information at risk would be a violation of trust placed in me as a healthcare provider. I also understand that any violation of this policy may result in jeopardizing my academic status as a nursing student at Northeast State Community College since the instructor has the authority to assign an "F" for the course in instances where confidentiality is breached. I have read and understand the policy entitled "Client Confidentiality in Clinical Assigned Areas" and the document provided entitled "Protecting the Privacy of Patients' Health Information".

_____	_____	_____
Signature	Initials	Print Name

NSCC-3 09-032

Consent Form

Place initials beside each section, in which you agree.

I. _____ I hereby give permission for the Northeast State Community College division of nursing to release information regarding my malpractice insurance policy and any clinical health care requirements requested to the clinical agency where I am assigned.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

II. _____ I have been informed the location of the *Nursing Student Handbook*. I have also been provided a copy of the Nursing Student Handbook. I agree to read and abide by the contents within. Failure to abide with the requirements stated herein will result in appropriate action by the Nursing faculty, the dean of Nursing, or appropriate college officials.

III. _____ Permission to Photocopy: I hereby give my permission for photocopying of my written work. I understand that this material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

IV. _____ I hereby give permission for the Northeast State Community College division of nursing to release my name, address and phone number for professional and recruiting purposes, i.e. employment. I authorize the educational instructor to answer all questions asked concerning my ability, character, reputation, and previous employment/educational record. I understand and acknowledge that my personal information (i.e., name, address, and phone number) may be confidential information in my educational record as protected by the Family Educational Rights and Privacy Act if I have requested NeSCC not designate that data as directory information; however, I consent to its release by the NeSCC Nursing Division for the limited purpose of employer recruiting. I release all such persons from any liability or damages on account of having furnished such information.

V. _____ I have read the Standard Precautions Procedure. I agree by my signature to abide by the contents within.

VI. _____ I understand that Northeast State Community College strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

VII. _____ I hereby give my permission for the Northeast State Community College Nursing Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the Nursing Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation and development, and publicity.

VIII. _____ I hereby give permission to release transcripts for official purposes: e.g., state licensure application: For TN residents: State of TN/Dept. of Health, Bureau of Health Licensure, Division of Health Related Board, 665 Mainstream Drive, Metro Center, Nashville, TN 37243; For VA residents: VA Board of Nursing, Perimeter Center 9960 Mayland Drive, Suite 300. Henrico Virginia 23233-1463 Note: This section must be signed to release transcript for licensure application.

I, _____, have read and understood this consent and release, and I have signed it voluntarily in consideration of enrollment in the Nursing Program at NeSCC.

VAIL (Virtual Academic Integrity Laboratory)
I have completed the following steps below with 80% of higher achievement score, printed out the completion sheet, and provided a copy of the completion sheet with this form.

- http://www.umuc.edu/students/academic-integrity/vail-tutorial.cfm
- Click on "Students"
- Click on "Tutorials" at top of page
- Click on "VAIL Tutor!" in blue font
- Click on "VAIL Tutor!" in blue font again
- Complete Modules 1, 2, 3, and 4
- Complete the Quizzes for modules 1, 2, 3 , and 4
- Print out and attach "Your final score is _____%" page.
- Successfully achieve 80% or higher (not 65%) and complete Quiz

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Background Check

APPLICANTS ARE HIGHLY ENCOURAGED TO BEGIN THIS PROCESS IMMEDIATELY! Do not delay in initiating the required procedures below as it may take longer than expected to get results from the vendor. In addition, if a discrepancy is identified by *Verified Credentials*, it may take weeks to obtain the needed documents to be cleared. The background check is completed through *Verified Credentials.*

To submit application to Verified Credentials for Background Check:

- Go to **scholar.verifiedcredentials.com/northeaststate**
- Enter the code below for the program you will be attending
  LPN to RN – Code: FGCDW-32387
- Create an account *or* if you already have a QualifiedFirst account, log back in as a "returning user" and enter the code at the top of your home page
- Enter all required information
- Review all information before submitting payment
- Payment can be made by credit card (Visa, MasterCard or Discover), or Pay Pal.
- Track progress through your QualifiedFirst (QF) account with the login you created.

Upon completion, *Verified Credentials* sends information to the student applicant and to the Dean of Nursing.

The information sent from *Verified Credentials* to the student applicant contains specific information related to the background screening and is sent via email.

- If the information shows "No Discrepancy" in all areas, the background check is considered "clear".
  - No additional action is required by the student applicant.
- If there is an identified discrepancy, it will also be noted for the applicant to review.
  - If any information is found that is not accurate, the student applicant can challenge the information through the Adverse Action process associated with *Verified Credentials* Client Services at 800.938.6090.
  - The student applicant will need to contact the Nursing Division (423.354.5509) to receive information regarding healthcare agency procedures for those seeking clearance. The healthcare organizations are the clearing agency for the student applicant. Healthcare agency documentation showing the student applicant has been "cleared" is required to be submitted with the nursing application packet.

The information sent from *Verified Credentials* to the dean of Nursing is non-specific/non detailed. The information is reported as Dean "No Discrepancy" or "Discrepancy"; no specific/detailed information is sent to anyone but the student applicant.

Drug/Alcohol Testing Consent - Statement of Acknowledgment and Understanding Release of Liability

I, _____, am enrolled in the Nursing Program at Northeast State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Northeast State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff and property. Accordingly, I understand that prior to participation in the clinical experience, I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing at any time based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Northeast State Community College.If I am a licensed health professional, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test result is positive. Full reinstatement of my license would be required for unrestricted return to the Northeast State Community College Nursing Program.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

My signature below indicates that:

1) I consent to drug/alcohol testing as required by clinical agencies, the Tennessee Professional Assistance Program, or as directed by the Office of Student Affairs.
2) I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the dean of the Nursing Program, and others deemed to have a need to know.
3) I understand that I will be required to pay a fee of $15.00 to the Tennessee Nurses Foundation (TNF) after admission to the major, and that I am responsible for payment of any required drug or alcohol screens. Nurses licensed in Tennessee will not have to pay an additional fee to TNF.
4) I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Northeast State Community College, and the Drug-Free Campus/Workplace Policy of Northeast State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
5) I hereby release and agree to hold harmless Northeast State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicates that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Nursing Program at Northeast State Community College.

_____	_____	_____
Student Applicant Signature	Student Applicant Identification Number	Date

NSCC-3 09-031

Core Performance Standards

All Tennessee Board of Regents (TBR) nursing programs have adopted the following core performance standards proposed by the Southern Council on Collegiate Education for Nursing (1992). Admission to and progression in nursing programs is not based on these standards; instead they will be used to assist each student in determining whether accommodations or modifications are necessary. Each of these standards is reflected in nursing course objectives and provides an objective measure for students and advisors to make informed decisions regarding whether the student is "qualified" to meet requirements. Copies of these standards will be available to every applicant and student. If a student believes that he or she cannot meet one or more of the core performance standards without accommodations or modifications, it is appropriate for the student to take the responsibility of identifying his or her need for accommodations to the Center for Students and Disabilities and course instructor. The needs of each self-identified student will be addressed on an individual basis when considering necessary accommodations, and it is recognized that helping to determine successful accommodation is the responsibility of the student, as well as the faculty member. The nursing program will cooperate with other college units to identify auxiliary aids and services which may be needed for reasonable accommodations.

Core Performance Standards for Admission and Progression

1. Critical thinking ability sufficient for clinical judgment.
2. Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.
3. Communication abilities sufficient for interaction with others in verbal and written form.
4. Physical abilities sufficient to move from room to room and maneuver in small spaces.
5. Gross and fine motor abilities sufficient to monitor and assess health needs.
6. Auditory abilities sufficient to monitor and assess health needs.
7. Visual ability sufficient for observation and assessment necessary in nursing care.
8. Tactile ability sufficient for physical assessment.

_____	_____
Student Applicant Signature	Student Applicant Identification Number

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Memorandum of Understanding Nursing Skills Lab Kit

I understand that purchasing a Nursing Skills Lab Kit is a requirement for NURS 1050. I understand the kit will be used in the Nursing Skills Lab setting with instructor assistance. I understand the contents of the Nursing Skills Lab Kit are to be used only on manikins in the skills lab. No invasive procedures are to be practiced on family, friends, neighbors, allies, enemies, relations, or animals. This includes any organism, living or dead. I understand the items in the Nursing Skills Lab Kit are not "play toys" or "play items" and that keeping the items secured in a safe place is my responsibility. I understand the items in the kit are to be used throughout the nursing program.

_____ _____

Student Applicant Name (Printed) Student Applicant Signature

Student Proof of Malpractice Insurance - Liability Insurance (Renewed Annually)

No divisional form required. Student must provide copy of insurance certificate with type of insurance, amount, and expiration date. Emails will not be accepted. All students enrolled in the Nursing program are required to purchase liability insurance annually. Current individual professional liability policy (not a group policy) with $1,000,000/$3,000,000 coverage is required.

A student who is already licensed as an RN or LPN must buy the appropriate liability insurance coverage **and** request to be licensed as a student. Verification that the additional student coverage is in effect must be submitted to the division of Nursing.

A copy of the declaration page of the policy (Certificate of Insurance or Policy Face Sheet) with policy number, expiration date, and liability amounts must be submitted. (There are no forms provided by the division of Nursing for you to submit for the Liability Insurance requirement therefore, a copy of the declaration page of the policy also known as the Certificate of Insurance with the policy number, expiration date, and liability amounts must be submitted to the division of Nursing).

Resources for liability insurance providers:

- Nurses Service Organization (NSO)
  - Phone: 1.800.247.1500
  - Fax: 1.800.739.8818
  - Web site: www.nso.com
  - Address: 159 E. County Line Road; Hatboro, PA 19040-1218

Note: If purchasing NSO liability insurance via online or telephone, student has the option of selecting an effective date.

- Chicago Insurance Company
  - Phone: 1-800-503-9230
  - Web site: www.proliability.com
  - Address: 1440 Renaissance Dr., Park Ridge, IL 60068-1400

Requirement for Application: Submission of HESI LPN to ADN Entrance Exam Scores

The entrance test required to be completed with scores submitted in your nursing application is the HESI LPN to ADN Entrance Exam. A score of 850 or higher is required on the Fundamentals Specialty section. For those scoring 850 or higher on the Medical Surgical Specialty section, extra points will be given on the applicant's ranking score. This exam must be taken within one year of the application due date, and may be repeated one time. To register for the exam, contact the Testing Center at 423-354-2587.

GPA Requirement

All pre-requisite and any co-requisite grades required for the Northeast State Community College AAS in nursing degree which have been transferred into Northeast State Community College and are therefore reflective on the Northeast State Community College official, unopened transcript will be used to calculate GPA for application and ranking purposes. The minimum Grade Point Average (GPA) required for making application to the AAS in nursing program is 2.75.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Northeast State Community College Division of Nursing LPN to RN Application

Application Deadline: Monday, March 3, 2014 at 3:00pm

Requirement for Application: GPA Calculation

All applicants to the Northeast State Community College AAS in nursing degree program must attempt to calculate his/her GPA using the instructions provided below.

1. Print off a copy of your Northeast State Community College transcript from *MyNortheast*.
2. Using the Calculation Work Space below, record the grade displayed on your transcript for each completed courses below in the "Grade" column.
3. Using the Calculation Work Space below, record the number of credit hours displayed on your transcript for each completed courses below in the "Credit Hours on Transcript" column.
4. Using the Calculation Work Space below, record the quality points displayed on your transcript for each completed courses below in the "Quality Points" column.
5. Using the Calculation Work Space below, add the numbers recorded in the "Credit Hours on Transcript" column and place total at the bottom in the "Total Credits" box.
6. Using the Calculation Work Space below, add the numbers recorded in the "Quality Points" column and place total at the bottom in the "Total Quality Points" box.
7. Using the Calculation Work Space below, divide the number you recorded in the "Total Quality Points" box by the number you recorded in the "Total Credits" box. (Total quality points/ total credit hours)
8. Using the Calculation Work Space below, enter the number obtained from the division calculation in the white circle provided.

Course	Course Name	Grade	Credit Hours on transcript	Quality Points	
BIOL 2010	Anatomy and Physiology I				
BIOL 2020	Anatomy and Physiology II		+	+	
ENGL 1010	Composition I		+	+	
MATH 1530	Probability and Statistics		+	+	
Computer Competency/ Proficiency Requirement	INFS 1010: Computer Applications (or) Credit by Examination at Northeast State Community College		+	+	
BIOL 1230	Introduction to Microbiology		+	+	
PSYC 1030	General Psychology		+	+	
SPCH 1010	Fundamentals of Speech Communication		+	+	
Humanities/ Fine Arts Elective	One of the courses below will fulfill the Humanities/Fine Arts elective requirement for the AAS in Nursing degree. If you have successfully completed more than one of the courses below, circle the course in which you achieved the highest grade and place the grade obtained in the column to the right.		+	+	
	ARTH 1030: Introduction to Art ARTH 2010: Survey of Art History I ARTH 2020: Survey of Art History II ENGL 2030: Literary Heritage ENGL 2110: American Literature I ENGL 2120: American Literature II ENGL 2130: American Masterpieces ENGL 2180: Myth and Tradition ENGL 2210: English Literature I ENGL 2220: English Literature II ENGL 2330: World Literature HUM 2010: Introduction to Humanities I HUM 2020: Introduction to Humanities II HUM 2340: Black Studies HUM 2350: Technology in Society MUS 1030: Music Appreciation PHIL 1030: Self and World PHIL 2020: Values and Society PHIL 2210: Introduction to the Study of Religion THEA 1030: Introduction to Theatre THEA 2010: Theatre History I THEA 2020: Theatre History II		= **Total Credits**	= **Total Quality Points**	**Total Quality Points** **Total Credits** = **GPA** Is the GPA $\geq$ 2.75? YES ☐ NO ☐

Complete the following questionnaire below by marking the "Yes" or "No" box for each question and completing any blanks provided.

YES ☐ NO ☐ I have applied to Northeast State Community College.

YES ☐ NO ☐ I have been accepted to Northeast State Community College.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

YES ☐	NO ☐		I have been assigned a NeSCC Student ID Number.
YES ☐	NO ☐		I have indicated AAS Nursing as my major on my application to Northeast State.
YES ☐	NO ☐		All courses I have completed for the AAS Nursing degree have a grade of "C" or better.
YES ☐	NO ☐		I have completed the HESI LPN-ADN Entrance Exam within one year of submitting this application.
YES ☐	NO ☐		I scored 850 or higher on the fundamentals section of the HESI LPN-AND Entrance Exam.
YES ☐	NO ☐		My completed scores for the HESI LPN-ADN Entrance Exam are provided with this application.
YES ☐	NO ☐		My GPA, as calculated in this application packet, is 2.75 or greater.
YES ☐	NO ☐		I am a licensed practical nurse.
YES ☐	NO ☐		I have provided a copy of my current, active LPN license with this application.
YES ☐	NO ☐		I have provided a copy of all clinical health care requirements with this application.
YES ☐	NO ☐		I have completed Wellmont required forms Exhibit A – F and included with my application packet.
YES ☐	NO ☐		I have completed the VAIL training.
YES ☐	NO ☐		I placed a copy of my VAIL score sheet in this application.
YES ☐	NO ☐		I have provided an unopened, official Northeast State Community College transcript in with my application packet.
YES ☐	NO ☐		I have completed BIOL 1230 with a "C" or better or am registered for BIOL 1230 during summer 2014.
YES ☐	NO ☐		I have completed PSYC 1030 with a "C" or better or am registered for PSYC 1030 during summer 2014.
YES ☐	NO ☐	N/A☐	I am applying for readmission to the program.
YES ☐	NO ☐	N/A☐	I have completed the Exit Interview form (if requesting re-admittance to the nursing program).
YES ☐	NO ☐	N/A☐	I have completed the written statement to the Dean of Nursing (if requesting re-admittance to the nursing program).
YES ☐	NO ☐	N/A☐	I have contacted the Nursing Division and scheduled testing for any NURS courses of which I have passed with a grade of "A", "B" or "C" (if requesting re-admittance to the nursing program).
YES ☐	NO ☐		My nursing application is all inclusive and fully completed.

Application Submission Instructions

The completed application packet must be mailed to the following: Northeast State Community College, Division of Nursing Attn: Nursing Application; 2425 Highway 75, PO Box 246; Blountville, TN 37617-0246

Hand delivered, faxed, emailed, or incomplete applications will be disqualified from ranking. Please do not place the application packet contents in an over-sized envelope, bubbled envelope, or photo mailers. For application purposes, flat envelopes which can easily fit into a standard filing cabinet are preferred. All mailed material, including envelopes, is retained by the Division of Nursing, and items that do not fold flat are difficult to file. Applications must be RECEIVED, not postmarked by, the Division of Nursing deadline date and time! Applicants have the option, at an additional cost, to send the application packet by certified mail, return receipt requested, Federal Express, or UPS to confirm receipt of their packet. The Division of Nursing will not respond to inquiries of receipt other than mail delivered by the services suggested above. The Division of Nursing is not responsible for lost or misdirected mail or mail that does not arrive in a timely manner. Please do not call or email the Nursing Division regarding the outcome of application. Decisions will be mailed within six (6) weeks after deadline or when ranking is completed. All applicants are notified of his/her status. Please do not call the division to see if results are finalized – this slows down the application ranking process. If you find that you will be out of town or otherwise unable to check your mail for your application result letter, please have someone that you trust to check your mail for correspondence from the Nursing Division. Applicants that are accepted into the program have a specified date by which to respond and accept their position in the program. Applicants that do not respond by the specified date on their acceptance letter will be considered to be declining their offered position in the program, and his/her position will be offered to the next qualified applicant.

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit A

WELLMONT HEALTH SYSTEM INFLUENZA (FLU) VACCINATION FORM FOR ALL STUDENTS

Per Wellmont policy regarding influenza vaccination requirements, the influenza (Flu) vaccination will, again, be a requirement of all health science students that participate in any clinical rotation or observation within any Wellmont facility.

Prior to approval of any student clinical rotation between December 1, through March 31, will require documentation of receipt of the influenza (Flu) vaccination for each student.

Documentation is to be submitted to the appropriate Wellmont facility for clinical rotation approval.

If documentation is not received by November 22, 2013 those students will not be allowed to participate in a student clinical rotation at any Wellmont facility.

The flu season is recognized to begin December 1, through March 31.

By signing this form, I am acknowledging that I have read the information on this form and have provided proof of receipt of the influenza vaccination which will be on record in my official school file.

All schools are required to maintain documentation of each student receipt of the influenza vaccination with their school records and will have it available upon request.

_____ I have received the Influenza (FLU) Vaccination and have documentation of receipt in my official school file which will be available upon request.

_____ _____ _____

Signature of Student Name of School Date

_____ I have verified documentation of receipt of the above information to be true, accurate, and complete

_____ _____

Signature of School Contact Verifying Information Date

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit B

Wellmont Health System

Notice for Students and Contract Personnel

1. HEPATITIS B VACCINE NOTICE/DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection.

I have had the vaccine. Proof is on file with my school, agency, or Wellmont.

I understand that I would need to arrange to be vaccinated with Hepatitis B vaccine through my physician or the State Health Department at my own expense. However, I decline Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I understand that I can receive the vaccine through my physician or the State Health Department at my own expense.

2. HIV – POST EXPOSURE PROPHYLAXIS

Although preventing blood exposures is the primary means of preventing occupationally acquired human immunodeficiency virus (HIV) infection, appropriate post-exposure management is an important element of workplace safety. Immediate treatment may reduce the risk for HIV transmission. If you are exposed to blood or body fluids from a person known to be HIV positive, you should report this immediately to your employer/school (if applicable). Treatment should be initiated promptly, preferably within 1-2 hours, and may be administered at Wellmont through the Emergency Department or at the healthcare provider of your/your employer's/your school's choice. If treatment is provided at Wellmont, it would be provided at your expense or that of your employer or school.

By my signature below, I indicate that I have read and understand the above notices.

_____ _____
Print Name Signature of Student

_____
Name of Contracting Agency or School

_____
Witness Date

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit C

WELLMONT NETWORK ACCESS REQUEST
STUDENTS ONLY

(Please print all information and fill out form completely) *IS Use: Assigned Login____*

Date: ____/____/____ Phone # (_____) _____ - _____ Project Number: _____

Current Login: _____ Employee Number: __XXX - _XX - _____
(List only Last 4 of Social Security Number)

Student Printed Name: _____ Job Title: _____
(As on professional license) First Middle Initial Last

College/School:_____Instructor Name:_____

Student Rotation Start Date:_____ Student Rotation End Date:_____

School Contact Phone Number_____Email Address:_____

Circle Facility: BRMC HVMC LP HCMH Other: _____

☐ New Employee ☐ Current Employee ☐ Previous Employee ☐ Non-Employee (Student)

HBOC Applications: HBOC Training Date: _____/_____/_____

Application	Menu	GUI View	Coordinator's Signature Approval Required

	Coordinator's Signature Approval Required
HED/Admin Rx	

STUDENT SIGNATURE_____DATE_____

SCHOOL INSTRUCTOR SIGNATURE_____DATE_____

If student will need Network Access Please Complete & Return

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit D

VEHICLE REGISTRATION FORM

DECAL - PLACE INSIDE THE REAR WINDOW, PASSENGER SIDE, LOWER CORNER HANGTAG - PLACE ON THE REAR VIEW MIRROR

NAME _____ BADGE #_____

WORK AREA _____

VEHICLE 1
TAG # _____ STATE _____

TYPE_____ COLOR _____

DECAL / HANGTAG # _____

VEHICLE 2
TAG # _____ STATE _____

TYPE_____ COLOR _____

DECAL / HANGTAG # _____

VEHICLES TO BE TAKEN OUT OF SYSTEM
TAG # _____ STATE _____

TYPE_____ COLOR _____

DECAL / HANGTAG # _____

Number where you can be reached: ( ) _____

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit E

Wellmont CONFIDENTIALITY AGREEMENT

It is the policy of Wellmont Health System to maintain the confidentiality of all patients and employee information and certain business information. Wellmont has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information.

In the course of my employment/assignment within Wellmont Health System, I may have access to and be involved in the processing of confidential patient information. I agree that I will not access information on patients for whom I have no responsibilities, nor access patient or other information unless I have a "need to know" the information to perform my specific job duties. I understand that such information must be maintained in the strictest confidence both at work and outside of work. As a condition of my employment/assignment, I hereby agree that, unless directed by my manager or his/her designee, I will not at any time during or after my employment/assignment with Wellmont, disclose any confidential information to any person whatsoever or permit any person whatsoever to examine or make copies of any confidential reports, records, or documents prepared by me, coming into my possession, or under my control, or use confidential information other than as necessary in the course of my employment/assignment. I understand that sharing such information except in the direct performance of my job duties is a violation of trust placed in me as a healthcare professional that jeopardizes the mission and survival of our organization.

I understand and agree that, as a user of Wellmont's information systems, my user identification code and my password is the legal equivalent of my signature. I am accountable for all transactions performed using this code and/or password and agree to not disclose this code or password to anyone or to attempt to learn or use another person's code or password. If I have reason to believe that my identification code is known, lost or stolen, I will immediately contact the I.S. Department to have my code "reset". I understand that the system may be monitored and audits and periodic checks will be performed to confirm my involvement with patients whom I have accessed.

I understand and agree that at no time will access through our electronic medical record system be permitted for any employee, physician or contractor to view their own personal medical records or family member's medical records. I understand and agree that any violation of this agreement may result in loss of computer system access, legal, and/or other corrective action up to and including termination.

_____

Signature Initials Date
(Employee, student, volunteer, Contractor, etc.)

_____

Print Name and Last 4 digits of SSN

_____

(First name, middle initial and last name)

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____

Application Deadline: Monday, March 3, 2014 at 3:00pm

Exhibit F

Wellmont Portal User Confidentiality and User Agreement

This document is confirmation to Wellmont Health System ("WHS") that I am fully aware of the implications of access to the computer systems of all WHS hospitals and affiliates and the confidentiality of the information to which I have access. I acknowledge that the data and/or information to be accessed will be patient medical record and health information that is confidential under law. I agree to maintain all such information in strict compliance with all applicable laws.

I understand that my login ID is the equivalent of my legal signature, and I will be accountable for all representations made at log in and for all work done under my login ID, including Physician Portal access by my employees, agents, or associates whether authorized by me or not. I acknowledge that nothing in this Agreement authorizes access to or disclosure of any records not otherwise permitted by law. I understand that the electronic data and information stored in the computer systems are confidential patient, financial, organizational, and practitioner data or information and must be treated with the same care as data and information in the paper records. I shall educate my employees and/or agents on their obligations to maintain confidentiality of information and to use sound information security practices when using the computer systems of WHS.

I will only access data for which I have patient care responsibilities, to perform authorized utilization review, quality assessment and improvement, payment activities or peer review participation as defined in the Medical Staff bylaws and/or policies, procedures and administrative directives of the hospital(s) at which I have privileges, and warrant that my employees, agents and associates will not access data unless directed by me for assisting me with patient care responsibilities.

I will not disclose my login ID and password to anyone including my employees, agents or associates and I will ensure that reasonable safeguards are followed to assure security over protected health information. I understand and acknowledge that unauthorized access to or disclosure of such information by me or my employees, agents or associates, may subject me to legal liability and/or cause WHS to defend a legal claim. I understand that I am responsible for any unauthorized access to, or improper disclosure of, confidential information accessed by me or my employees, agents or associates. If I believe the security of my login ID and password has been compromised or broken, I will immediately change my password and contact WHS Client Services. I understand that my use may be monitored and audits and periodic checks will be performed to confirm my involvement with patients whom I have accessed.
Should a breach in information security occur, I will notify Wellmont IS Client Services. I will exercise reasonable efforts to retrieve improperly used or disclosed Protected Health Information ("PHI"), establish, revise or adopt new practices, policies and procedures to assure that PHI is not used or disclosed in the future in violation of HIPAA Privacy Standards. I will comply with all auditing or reporting requests to demonstrate compliance with the HIPAA Privacy Standards

I understand the misuse of my permitted access to the computer systems of WHS hospitals and/or misuse of confidential information by me or my employees, agents or associates may subject me to disciplinary action, including, but not limited to, immediate termination of this agreement to access and further disciplinary action in accordance with the Medical Staff bylaws and/or rules and regulations of the hospital(s) at which I have privileges, up to and including termination of my medical staff membership and privileges as well as civil or criminal legal penalties.

_____ User's Signature _____User's Printed Name

xxx-xx-_____ (last four digits of SSN for password verification purposes)

_____ _____
Witness Date

I certify that the above information is true and complete and is made in good faith. I understand that if accepted, falsified statements on this application shall be considered sufficient cause for disqualification or dismissal. I understand that I must provide all requested documents in the application packet; failure to do so shall result in immediate disqualification of application or dismissal from the program. I have read and understand all information contained on this page. Please do not call the Division for application questions as this slows the ranking process. Questions may be sent to nursingmail@NortheastState.edu

Applicant's Printed Name_____ Applicant's Signature_____

Applicant's Student ID Number_____Date_____