WILLIAM PATERSON UNIVERSITY

INITIAL CLINICAL HEALTH CLEARANCE GUIDE

Pre-entrance and periodic health evaluations are required by all students in the nursing major going to a clinical setting. This required data meets the requirements of the state of New Jersey Department of Health, as well as the various clinical agencies in which students affiliate. Carefully review the requirements below to successfully complete the attached Health Clearance Packet in its entirety. **All clinical clearance documentation requirements are due 14 days prior to the start of the clinical course. If a student is not cleared 7 days prior to the start of the first day of their clinical course, they will be administratively dropped without warning. NO EXCEPTIONS**

Initial Health Clearance Requirements:

1. **Initial Physical Exam for Clinical Clearance** form completed (front and back pages): Student must have a physical exam performed by a healthcare provider within 1 year of clinical start date. All information must be completed, including vision/color screen, date of physical exam, signed and stamped by the healthcare provider. Upload in Exxat.

2. **QuantiFERON-TB Gold/ T-SPOT (blood test**) within 3 months of clinical start date. Student must submit a copy of the lab report. Upload in Exxat.

   - **Positive QuantiFERON-TB/T-SPOT test: Action Required**
     Please submit a post-positive chest x-ray report. Documentation of (prophylactic) medication regimen by a healthcare provider required and yearly documentation of TB symptoms check.

3. **Complete blood count (CBC) lab report** within 1 year of clinical start date. Upload in Exxat.

4. **Varicella (Chickenpox):**
   IgG titer (laboratory blood test for antibodies): must submit a copy of the lab report regardless of past history of disease or vaccination. Upload in Exxat.

   - **For Negative Varicella Titer: Action Required:**
     If there is documented history of 2-dose Varicella vaccinations, then *1 dose of Varicella booster vaccine is required.* If there is no documented vaccination history, then 2 dose Varicella vaccination is required: second dose at least 28 days after the first dose. Please submit vaccination record, if not done so already. Upload in Exxat.

   - **For Equivocal Varicella Titer**:
     If there is documented history of 2-dose Varicella vaccination, then a booster is *highly recommended* but not required. If the student has only received 1 dose of the vaccine in the past then a *second dose of the vaccine is required.* Upload in Exxat.

5. **Measles, Mumps, and Rubella (MMR):**
   IgG titer (laboratory blood test for antibodies): must submit a copy of the lab report with each results. Upload in Exxat.

   - **For Negative Measles, Mumps, or Rubella Titer Results: Action Required:**
     If there is documented history of 2-dose MMR vaccinations, then *1 dose of MMR booster vaccine is required.* If there is no documented vaccination history, then 2 dose MMR vaccination is required: second dose at least 28 days after the first dose. Please submit vaccination record, if not done so already. Upload in Exxat.

- **For Equivocal Measles, Mumps, or Rubella Titers**:
  If there is documented history of 2-dose MMR vaccination, then a booster is *highly recommended* but not required. If the student has only received 1 dose of MMR vaccine in the past then a *second dose of the vaccine is required.* Upload in Exxat.

6. **Hepatitis B**

   Documentation of **positive Hepatitis B Surface Antibody test**: must submit a copy of the lab report. Upload in Exxat.

- **For Negative Hepatitis B Surface Antibody: Action Required**
  If there is documented history of 3-dose Hepatitis B vaccinations, then *1 dose of Hepatitis B booster vaccine is required.* If there is no documented vaccination history, then 3-dose Hepatitis B vaccination is required at 0, 1, and 6-month intervals. Upload in Exxat.

7. **Tetanus/Diphtheria/Pertussis Vaccine (Tdap/Td)**

   Documentation with date of vaccination of Tdap vaccine in a lifetime and Td booster every 10 years. If no documentation of Tdap is presented a single dose of Tdap is required. Upload in Exxat.

8. **Covid 19 vaccine**

   A copy of your Covid 19 vaccine record is required. Exemptions must be vetted by a physician. Upload in Exxat.

9. **Flu vaccine**

   Documentation of annual flu vaccine during the flu season (August through May). Upload in Exxat.

10. **Clinical Student Request and Authorization to Release Records and/or Information Form:** must be signed and dated annually. Upload in Exxat.

11. **Urine Drug Screen and background check** need to be completed annually. Results will be posted in Exxat.
    *Note, the initial background check must be completed first. The background recheck should only be completed when the initial background check is about to expire or has expired.

Please submit **ALL** completed forms and documents to Exxat. **Incomplete forms and documents will not be accepted and will cause a delay in your clearance.**

- **Exxat** will review the documents uploaded and categorize them as approved, pending, or not approved. **Exxat** will provide comments on documents that need further explanations and/or supplemental documentation. **Please check all comments before reaching out**. Exxat support, v4support@exxat.com.

For further questions, please contact your program clinical coordinator:

Undergraduate Clinical Coordinator:	Iryna Surmachevska, surmachevskai@wpunj.edu
Graduate Program Assistant:	Jami Jennings, jenningsj3@wpunj.edu
WP Online Clinical Coordinator:	Ivy Sosoban, sosobani@wpunj.edu

William Paterson University

Physical Exam for *Initial* Clinical Clearance- Page 1

INCOMPLETE FORMS/DOCUMENTS WILL NOT BE ACCEPTED

Upload completed forms and all required documents in Exxat:

Patient Name: _____ **DOB:** _____

Student ID#: 855_____ **Contact Phone#** _____

Program *(select one):* Nursing Graduate Nursing DNP Communication Disorders

Allergies *(specify reaction)*:_____ **Current Medications**:_____

Past Medical History _____

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1. Physical Examination ***(To be filled out by a medical provider)*** **LMP** _____

HT_____ **WT**_____ **BP**_____ **HR**_____ **RR**_____ **TEMP**_____

Vision Screen-mandatory: Left Eye_____/_____Right Eye_____/_____ *Circle:* With / Without Correction

Color testing *(circle):* Pass Fail

	WNL	Abnormal/Comments
General		
Skin		
Nodes		
HEENT		
Mouth		
Chest/Breast		
Lungs		
Heart		
Abdomen		
Gent/Rect		
Extremities/Hips		
Back/Spine		
Musculoskeletal		
Neuro		

2. Assessment:

Patient is medically cleared to participate in the clinical setting ***(circle):*** **Yes** **No**

If no, explain reason _____

_____

Provider Name & Signature **Date**

Provider's Stamp (Required)

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Physical Exam for *Initial* Clinical Clearance- Page 2

(All the information below is to be filled out by a medical provider and stamped at the bottom)

Patient Name: _____

3.
Tuberculosis Screening *(via blood test):* DOB:

Provide a copy of QuantiFERON TB-Gold –or- T-SPOT lab test results within the last 3 months

- **Positive QuantiFERON-TB-Gold/ T-SPOT test: Action Required**

Please submit a post-positive chest x-ray report. Documentation of (prophylactic) medication regimen by a healthcare provider required and yearly documentation of TB symptoms check.

CXR Date(s):_____ **Results**: Negative Positive

TB Symptoms Assessment (date & results): _____

Prophylaxis/Treatment History *(Include date started and end date):* _____

Precautions and follow-up instructions: _____

If treatment is not recommended, give reason: _____

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4. CBC: Provide copy of complete blood count lab report completed within 1 year of clinical start date

5. Measles, Mumps, Rubella & Varicella Titers: Provide copy of the titer lab results, **not** the vaccine dates

Non-immune titer results *require* a booster *Equivocal* titer results, booster recommended

_____ _____

MMR Booster Date *(if applicable)*_____ Varicella Booster Date *(if applicable)* _____

6. Hepatitis B Vaccine: *Provide copy of positive Hepatitis B Surface Antibody test result*

For **Negative Hepatitis B Surface Antibody***: Action Required*

If there is documented history of 3-dose Hepatitis B vaccinations, then 1 dose of Hepatitis B booster vaccine is required. If there is no documented vaccination history, then 3-dose Hepatitis B vaccination is required at 0, 1, and 6-month intervals.

_____ _____ _____

7. Tdap* Vaccine: *(tetanus, diphtheria & pertussis)* within the last 10 years. Vaccine Date: _____

8. Flu* Vaccine: *annually during current flu season* Vaccine Date: _____

Provider's Stamp (Required)

William Paterson University
Clinical Student Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the School of Nursing, to release protected information from your clinical record to the person or agency you designate.

I,_____, authorize the School of Nursing
(Print name of student)

and administrative staff, and Exxat to release information to one another regarding my clinical physical and any relevant information related to participation in the nursing program at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care. This authorization shall remain in effect for one year from the date signed below (unless otherwise indicated).

I understand that I have the right to revoke this authorization in writing, at any time by uploading such written notification to Exxat.

However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Student ID# Date of Birth

_____ _____
Signature of student (*parent if minor)* Date

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