AT 4th Year Requirements

REQUIREMENT:	GUIDELINES:	DUE DATE	EXP. DATE	DOCUMENT REQUIRED:	ADDITIONAL INFORMATION:
CPR	One of the following is required: A) American Heart Association Basic Life Support for Health Care Providers OR B)American Red Cross Professional Rescuer ONLY	As needed	Certification must remain valid for entire clinical experience	Copy of front and back of CPR certification card with signature	Certification must remain valid for entire clinical experience.
PROOF OF HEALTH INSURANCE	Provide a copy of your current health insurance card And Proof of Health Insurance form	Before 07/14/18	If your insurance changes, you are responsible for providing updated information	Copy of insurance card or equivalent AND Proof of Health Insurance form	
HIPAA/OSHA TRAINING	Complete your HIPAA/OSHA training via the Evolve e-Learning Solutions website at: https://www.evolvelms.com/lms/uvm/default.aspx	Before 07/14/18	Annual requirement	No need to submit a document as long as you've completed your training online	Training will not be considered complete unless all sections of the training have been completed.
INFLUENZA VACCINATION	Influenza vaccination for current flu season	After 10/1/2018 and Before 10/30/2018	Valid for current flu season	Completed on school form or health care provider's form	

AT 4th Year Requirements

Notes from CNHS – Lisa McClintock

Please be sure to fill out the top of each form with your identifying information before submitting it to CastleBranch.

It is your responsibility to keep track of whether you have submitted your requirements.

If you know you will be unable to meet the above deadlines for extenuating circumstances, you should schedule a meeting with Lisa McClintock – lisa.mcclintock@med.uvm.edu

The UNIVERSITY of VERMONT
COLLEGE OF NURSING & HEALTH SCIENCES

Name: _____
Date of Birth: _____
Program / Graduation Year: _____
Date: _____

INFLUENZA VACCINE PRE-CLINICAL REQUIREMENT

Influenza Vaccination

Date Administered _____ Manufacturer _____

Lot Number _____ Expiration Date _____

Licensed Heath Care Provider Attestation

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress in his/her major** at the University of Vermont.

_____ _____ _____
Signature of **Licensed Health Care Provider** **Credentials** Date

_____ _____
Clinic Stamp or Printed Name of Provider Provider Telephone Number

It is MANDATORY that you scan and upload this form to CastleBranch

The Center for Health and Wellbeing will not submit your paperwork for you. You will need to pick up your documents and submit them to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.

The UNIVERSITY of VERMONT
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Name: _____
Date of Birth: _____
Program / Graduation Year: _____
Date: _____

CNHS INSURANCE REQUIREMENTS

Proof of Health Insurance Form- Submit this form AND copy of insurance card

**The University does not pay medical costs resulting from injury during clinical/practicum rotations or other curricular activity unless this injury is due to negligence of the University. All CNHS students are required to carry their own health insurance. It is your responsibility to resubmit your insurance if there are any changes.*

Subscriber/Member ID _____ Primary Subscriber's Name _____

Insurance Carrier _____ Subscriber's Relationship to You _____

It is MANDATORY that you scan and upload this form AND a copy of your insurance card to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.