## AT 4th Year Requirements

<table>
<thead>
<tr>
<th>REQUIREMENT:</th>
<th>GUIDELINES:</th>
<th>DUE DATE</th>
<th>EXP. DATE</th>
<th>DOCUMENT REQUIRED:</th>
<th>ADDITIONAL INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>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</td>
<td>As needed</td>
<td>Certification must remain valid for entire clinical experience</td>
<td>Copy of front and back of CPR certification card with signature</td>
<td>Certification must remain valid for entire clinical experience.</td>
</tr>
<tr>
<td>PROOF OF HEALTH INSURANCE</td>
<td>Provide a copy of your current health insurance card AND Proof of Health Insurance form</td>
<td>Before 07/14/18</td>
<td>If your insurance changes, you are responsible for providing updated information</td>
<td>Copy of insurance card or equivalent AND Proof of Health Insurance form</td>
<td></td>
</tr>
<tr>
<td>HIPAA/OSHA TRAINING</td>
<td>Complete your HIPAA/OSHA training via the Evolve e-Learning Solutions website at: <a href="https://www.evolvelms.com/lms/uvm/default.aspx">https://www.evolvelms.com/lms/uvm/default.aspx</a></td>
<td>Before 07/14/18</td>
<td>Annual requirement</td>
<td>No need to submit a document as long as you’ve completed your training online</td>
<td>Training will not be considered complete unless all sections of the training have been completed.</td>
</tr>
<tr>
<td>INFLUENZA VACCINATION</td>
<td>Influenza vaccination for current flu season</td>
<td>After 10/1/2018 and Before 10/30/2018</td>
<td>Valid for current flu season</td>
<td>Completed on school form or health care provider’s form</td>
<td></td>
</tr>
</tbody>
</table>

---

**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
### INFLUENZA VACCINE PRE-CLINICAL REQUIREMENT

#### Influenza Vaccination

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lot Number</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Licensed Health 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 fields]

- **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.
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.