TECHNI-PRO INSTITUTE

RN, PN, RN to BSN, Hemodialysis Technician, Home Health Aide, Accounting & Medical Office

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TO: _____ **DATE:** _____

FROM: **The Clinical Administrator's Office**

Please provide **ALL** the following documents for your file as soon as possible to be able to attend your clinical rotation:

		For Office Use ONLY
❑	Physical Examination **(Within 6 months)**	*Date:* _____
❑	**Current** American Heart Association CPR Card	*Exp. Date:* _____
❑	Level II Background Check/Fingerprint **(FDLE)**	*Date:* _____
❑	**NEGATIVE** 10 Panel Urine Drug Screen **(Within 1 year)**	*Date of last screen:* _____
❑	Hepatitis B Vaccine Immunization (3 doses) **or** Hepatitis Titer	*Dates of **3** doses **or** date of positive titer* _____ _____ _____
❑	MMR Vaccine Immunization (2 doses) **or** MMR Titer	*Dates of **2** doses **or** date of positive titer* _____ _____
❑	Varicella Vaccine Immunization (2 doses) **or** Varicella Titer	*Dates of **2** doses **or** date of positive titer* _____ _____
❑	**Annual/Seasonal** Flu Vaccine	*Date:* _____
❑	TDAP **(Within the last 2 years)**	*Date:* _____
❑	**NEGATIVE** PPD or Chest X-Ray **(Within a year)**	*Date:* _____
❑	Background Check ORI# V500-300-61	*Date:* _____

NOTE: Please check with the Clinical Administrator's Office as soon as possible to confirm that your student file requirements are complete in order to participate in Clinicals. You may be removed from the clinical rotation or rescheduled for a later clinical rotation if the above documents are not received 3 weeks before the clinical date.

I acknowledge receipt of and understanding of this information.

_____ _____

Print Name Date

_____

Signature