



TECHNI-PRO INSTITUTE

RN, PN, RN to BSN, Hemodialysis Technician

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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:

		Reviewed By
<input type="checkbox"/>	Physical Examination (Within 12 months)	Date: _____
<input type="checkbox"/>	Current American Heart Association CPR Card	Exp. Date: _____
<input type="checkbox"/>	Level II Background Check/Fingerprint (FDLE) ORI# V500-300-61 (5 Years)	_____
<input type="checkbox"/>	NEGATIVE 10 Panel Urine Drug Screen (6 Months)	Date of last screen: _____
<input type="checkbox"/>	Hepatitis B Vaccine Immunization (3 doses) or Hepatitis Titer	Dates of 3 doses or date of positive titer _____ _____ _____
<input type="checkbox"/>	MMR Vaccine Immunization (2 doses) or MMR Titer	Dates of 2 doses or date of positive titer _____ _____
<input type="checkbox"/>	Varicella Vaccine Immunization (2 doses) or Varicella Titer	Dates of 2 doses or date of positive titer _____ _____
<input type="checkbox"/>	Annual/Seasonal Flu Vaccine	Date: _____
<input type="checkbox"/>	Covid Vaccine (Required)	Date: _____
<input type="checkbox"/>	TDAP (Within the last 10 years)	Date: _____
<input type="checkbox"/>	NEGATIVE PPD or QuantiFERON Test (Within a year)	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