

## **Health/Clinical Practice Requirements**

### **OVERVIEW**

Advanced practice and prelicensure nursing students must comply with regulations set by the New York State Department of Health, the Decker School of Nursing, Binghamton University and affiliated agencies.

Compliance is verified prior to and immediately following all deadlines.

### **DEADLINES\***

Refer to the Decker College Requirements webpage ([www.binghamton.edu/decker/about/requirements.html](http://www.binghamton.edu/decker/about/requirements.html)) for deadlines; if the date isn't posted yet, keep checking back.

For continuing students, health/clinical practice requirements are due one calendar year from the date they were completed. Students may need to repeat the requirements within the academic year to maintain current health/clinical practice requirement status.

\*Failure to comply and/or maintain health/clinical practice requirements will negatively impact your time to degree.

### **HEALTH/CLINICAL PRACTICE REQUIREMENT QUESTIONS**

All questions regarding health/clinical practice requirements may be directed to [deckreqs@binghamton.edu](mailto:deckreqs@binghamton.edu).

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## **MEDICAL DOCUMENT MANAGER**

Health/clinical practice requirements are managed through CastleBranch. All requirements must be uploaded by the student and accepted as complete by the health/clinical practice requirement coordinator in the medical document manager (CastleBranch) by the appropriate deadline. Incomplete, incorrect and illegible forms will be rejected. Rejected or missing health documents after the deadline will negatively impact your progression. Note that it takes 5–7 days for an uploaded document to be evaluated and confirmed or denied, so be sure to allow yourself enough time for this process to occur.

Follow the CastleBranch instructions on page 6 of this packet to create an account.

The Decker School of Nursing does not accept emailed, faxed or hard copies of health documents. Login to your account from a laptop or desktop to review comments and/or instructions for rejected documents (not viewable on a portable device such as a mobile phone or tablet).

### **Additional information**

Your name must match our campus records on all documents. If your name has changed due to marriage, divorce, etc. you must also submit a legal document such as a marriage certificate, divorce decree or court granted petition as proof of identity with each requirement.

All uploaded documents must be clear, legible and complete. All four corners of each document must be visible or the document will be rejected.

## **DECKER STUDENT HEALTH SERVICES**

The Decker Student Health Services Center is a primary care facility for all registered students at Binghamton University. The mandatory student health fee ([www.binghamton.edu/health/services/health-fee.html](http://www.binghamton.edu/health/services/health-fee.html)) entitles you to visit the center at no charge (some services have costs associated). Be advised that this is the University's health clinic and not associated with the Decker School of Nursing. For more information about services provided, visit the center's website at [www.binghamton.edu/health](http://www.binghamton.edu/health) or call 607-777-2221.

If you are enrolling at Binghamton University for the first time, you are required by the University to submit medical history and immunization forms to the Decker Student Health Services Center. Visit the University's immunization requirements page ([www.binghamton.edu/health/immunization-requirements.html](http://www.binghamton.edu/health/immunization-requirements.html)) for information and instructions on completing Binghamton University health requirements.

**The University health requirements are separate from the Decker School of Nursing health requirements. Students must complete both the Binghamton University requirements AND the Decker School of Nursing health requirements.**

## **RELEASE FORM**

Site affiliations require specific student health data for participation in clinical experiences. Complete and upload the student health information release form (see page 7 of this packet) to your CastleBranch account for permission to forward the requested information to your assigned clinical agencies.

## **HEALTH EVALUATION FORM**

Have a healthcare provider complete the health evaluation form (see pages 8-9 of this packet). The physical examination section of the form must be completed by your provider (resubmit annually). You may submit immunization records or have your provider complete the immunization portion of the form.

Once completed, upload a copy to your CastleBranch account.

- **Tetanus:** All students must have had one dose of diphtheria-tetanus toxoid vaccine within the past 10 years. Your provider must indicate which combination (Td or Tdap) of the immunization you received.
- **Measles, Mumps, Rubella:** provide one of the following:
  - two MMR immunizations (month, date and year) after the age of 12 months
  - proof of serologic immunity to the communicable diseases (titers)
    - Upload titer (lab) results to each appropriate section in CastleBranch.
- **Varicella** (chickenpox): provide one of the following:
  - Documentation of receiving the series (2) (month, date and year)
  - a positive titer (upload lab results)
  - diagnosis of history of varicella disease by a healthcare provider (month, date and year disease was acquired)
- **Hepatitis B:** provide one of the following:
  - proof of completion of the series
  - proof you are in the process of receiving the series
  - signed declination form
- **Tuberculin test (PPD):** provide one of the following:
  - proof of two separate negative tuberculin tests placed within the past 12 months (at least 7 days apart) required initially, one annually thereafter.
  - chest x-ray (clear within 5 years)
  - Quantiferon Gold or t-spot blood test (submit annually)

Students who have a chest x-ray or Quantiferon Gold or t-spot test must complete a TB symptom screening form (see page 10 of this packet) annually.

## **INSURANCE**

Students are required to submit proof of current, personal health insurance coverage. If you submit your health insurance card (front and back) and your name is not imprinted, you must also submit supporting documentation for verification. (Resubmit annually.)

## **CPR**

Complete one of the following courses:

- American Heart Association: Basic Life Support for Healthcare Providers
- American Safety & Health Institute: CPR Pro
- American Safety & Health Institute: Basic Life Support for Healthcare Providers and Professionals

Note: The course must have a hands-on component; purely online courses will not be accepted. (Resubmit biennially.)

## **CONFIDENTIALITY**

Complete and upload the Decker School of Nursing confidentiality agreement (see page 11 of this packet). (Resubmit annually.)

## **HIPAA/OSHA BLOODBORNE PATHOGENS/INFECTION CONTROL TRAINING**

Graduate students must provide proof of completion and submit to CastleBranch. Undergraduate students complete this requirement as part of the nursing program.

## **CRIMINAL BACKGROUND CHECK**

Affiliated agencies often require criminal background checks. The extent of the investigation varies by facility, with some requiring more extensive federal clearances and fingerprints. To comply with the state of Pennsylvania, ALL STUDENTS should complete a free Pennsylvania Criminal Record Check ([www.psp.pa.gov/pages/request-a-criminal-history-record.aspx](http://www.psp.pa.gov/pages/request-a-criminal-history-record.aspx)) then upload the certificate to your CastleBranch account. (Resubmit biennially.) Students may have to complete other background checks for specific clinical sites, as well.

## **CHILD ABUSE CLEARANCE**

Complete the online application through CastleBranch. Once completed, you will receive a certificate that you must upload. (Resubmit biennially.)

## **RN LICENSE**

All post-licensure students must upload a copy of their valid unencumbered RN license with name, license number and expiration date. Screenshots will be rejected. (Resubmit prior to expiration.)

## **FLU VACCINE - due October 1**

To prove you received your annual vaccine, upload proof of vaccine that includes the following: your name; the location you received the vaccine; the date you received the vaccine; the name of the individual who administered the vaccine; which arm you received the vaccination in; and the vaccine name, manufacturer, lot # and expiration date. Upload this proof to your CastleBranch account by October 1 each year. (Resubmit annually.)

## **COVID-19 VACCINE**

Students entering nursing programs are required to complete clinical learning experiences in healthcare agencies. At this time, and for the foreseeable future, all New York state healthcare agencies require that all employees, including nursing students, be fully vaccinated for COVID. These healthcare agencies don't allow religious exemptions and have very narrow guidelines for medical exemptions. Any religious exemption granted by Binghamton University applies only to the University setting; it does not apply to off-campus affiliated activities, such as clinical placements within Department of Health (DOH) regulated agencies. The inability to complete a clinical rotation within a DOH-regulated facility will affect a student's ability to progress within and graduate from a nursing program.

**Decker School of Nursing  
Health/Clinical Practice Requirement Checklist**

This is a supplemental checklist. Thoroughly review the detailed health/clinical practice requirements document for important information.

<input checked="" type="checkbox"/>	LIST ITEM	DESCRIPTION	ADDITIONAL INFORMATION	RESUBMIT
<input type="checkbox"/>	<b>Medical Document Manager</b>	<input type="checkbox"/> Create a CastleBranch account	The Decker School of Nursing does not accept emailed, faxed or hard copies of health documents.  Login to your account from a laptop or desktop to review comments and/or instructions for rejected documents (not viewable on a portable device such as a mobile phone or tablet).	
<input type="checkbox"/>	<b>Student Health Information Release Form</b>	<input type="checkbox"/> Student health release form	Submission grants the Decker School of Nursing permission to forward the requested information to your assigned clinical agencies.	
<input type="checkbox"/>	<b>Student Health Evaluation Form</b>	<input type="checkbox"/> Physical examination section (completed by provider)  <input type="checkbox"/> Tuberculin	Students who have a chest X-ray or Quantiferon Gold or t-spot test must complete a TB symptom screening form annually.	Annually
<input type="checkbox"/>	<b>Student Health Evaluation Form</b>	<input type="checkbox"/> Meningitis (Decker Health Services Requirement) <input type="checkbox"/> Tetanus (valid for 10 years) <input type="checkbox"/> Rubeola (Measles) <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella <input type="checkbox"/> Hepatitis B	Be sure all information provided on your immunization record is legible.  You may submit immunization records or have your provider complete the immunization portion of the form.  If you have titer lab results, they must be uploaded to CastleBranch.	
<input type="checkbox"/>	<b>Insurance</b>	<input type="checkbox"/> Proof of current, personal health insurance coverage	If you submit your health insurance card and your name is not imprinted, you must also submit supporting documentation for verification.	Annually
<input type="checkbox"/>	<b>CPR</b>	<input type="checkbox"/> CPR card (signed) or electronic certificate from a professional provider/healthcare provider course	Accepted courses:  <input type="checkbox"/> American Heart Association: Basic Life Support for Healthcare Providers <input type="checkbox"/> American Safety & Health Institute: CPR Pro <input type="checkbox"/> American Safety & Health Institute: Basic Life Support for Healthcare Providers and Professionals	Biennially
<input type="checkbox"/>	<b>Confidentiality</b>	<input type="checkbox"/> Confidentiality agreement	Decker School of Nursing's confidentiality form	Annually
<input type="checkbox"/>	<b>HIPAA/OSHA Bloodborne Pathogens/Infection Control Training</b>	<input type="checkbox"/> Proof of completion (graduate students only)	Undergraduate students complete this requirement as part of the nursing program	
<input type="checkbox"/>	<b>Criminal Background Check</b>	<input type="checkbox"/> Pennsylvania criminal record check certificate	Required regardless of clinical site placement	Biennially
<input type="checkbox"/>	<b>Child Abuse Clearance</b>	<input type="checkbox"/> Child abuse clearance certificate	Required regardless of clinical site placement	Biennially
<input type="checkbox"/>	<b>RN License</b>	<input type="checkbox"/> Valid unencumbered RN license	For post-licensure students only	Before expiration
<input type="checkbox"/>	<b>Flu Vaccine (Due October 1)</b>	<input type="checkbox"/> Proof of vaccine (document with required information)		Annually
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**All questions regarding health/clinical practice requirements may be directed to [deckreqs@binghamton.edu](mailto:deckreqs@binghamton.edu).**

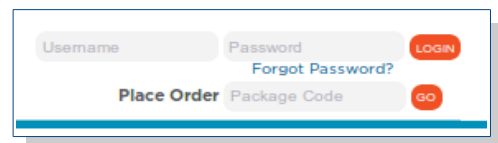


Binghamton University - Nursing  
Instructions for Order Placement

# Welcome to myCB!

When you place your initial order, you will be prompted to create your secure myCB account. From within your myCB, you will be able to:

- ✓ View your order results
- ✓ Upload and store important documents and records
- ✓ Manage requirements specific to your programs
- ✓ Place additional orders as needed.
- ✓ Complete tasks as directed to meet deadlines



To place an order, go to [mycb.castlebranch.com](http://mycb.castlebranch.com)

In the “Place Order” field, enter the following package code specific to your organization:

**BI05jr** : Abuse - Medical Document Manager

During order placement you will be asked for personal identifying information needed for security or compliance purposes. Supplying accurate and comprehensive information is important to the speed in which your order is completed.

The email address you use when placing your order will become your username for your myCB and will be the primary form of communication for alerts and messages. Payment methods include: MasterCard, Visa, debit card, electronic check, money order, and installment payment.

## TO-DO LISTS

You can respond to any active alerts or To-Do List items now, or return later by logging into your myCB. You will receive alerts if information is needed to process your order. Access your myCB anytime to view order status and completed results. Authorized users at your organization will have access to view your compliance status from a separate CastleBranch portal.

Your myCB Service Desk is available to assist you via phone, chat and email  
Monday-Thursday 8:00 am-8:00 pm & Friday 8:00 a.m. - 6:30 p.m. & Sunday 10am- 6:30pm EST  
888-914-7279 or [servicedesk.cu@castlebranch.com](mailto:servicedesk.cu@castlebranch.com)

### Student Health Information Release Form

**IMPORTANT:** The Decker School of Nursing is required to provide specific student health information to the agencies in which you will have a clinical experience.

Verification of Fulfillment of Student Health Requirements Pursuant to NYS 405.3 Health Code.

Agencies have the right to require health information in addition to:

1. Physical examination
2. Tetanus
3. Measles
4. Mumps
5. Rubella
6. Varicella
7. Hepatitis B
8. Tuberculin
9. Meningitis
10. Health insurance
11. CPR certification
12. Confidentiality agreement
13. Criminal background check
14. Child abuse clearance
15. Flu vaccine
16. RN license (if applicable)

### RELEASE

I authorize the Decker School of Nursing to forward my health information, as described above, to healthcare agencies in connection with my participation in clinical experiences in the:

- Undergraduate program.
- Graduate program.

Additional information from my student health file may be released as requested by a clinical agency.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Student Health Evaluation Form**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Home Phone ( ) - - Home Phone ( ) - - E-Mail \_\_\_\_\_

**Tuberculin Testing**

Tuberculin test (PPD): one of the following required:

- proof of two separate negative tuberculin tests placed within the past 12 months (at least 7 days apart) required initially, one annually thereafter
- chest X-ray (clear within 5 years)
- Quantiferon Gold or t-spot blood test (submit annually)

Students who have a chest X-ray or Quantiferon Gold or t-spot test must complete the tuberculosis screen annually.

1. Date administered: \_\_\_\_\_ Date read: \_\_\_\_\_ MM Induration: \_\_\_\_\_

2. Date administered: \_\_\_\_\_ Date read: \_\_\_\_\_ MM Induration: \_\_\_\_\_

**Signature of Healthcare Provider:** \_\_\_\_\_

If positive, chest X-ray is required. Chest x-ray Date: \_\_\_\_\_ Result: \_\_\_\_\_  
Include a copy of the chest X-ray report

**Physical Examination**

This is to confirm that on (date of exam) \_\_\_\_\_, I have reviewed the Physical Examination and Medical History for the above named. I believe he/she is free from any health impairment or communicable disease which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substance which might alter the individual's behavior.

**Signature of Examining NP/PA/Physician:** \_\_\_\_\_

License/Certification No. \_\_\_\_\_

Name and Title of Nurse Practitioner/Physician (Print) \_\_\_\_\_

Address \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

Telephone ( ) - - Date \_\_\_\_\_



### Immunization Record

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

#### Meningitis (Decker Health Services Requirement)

I have (or for students under 18, my child has):

- had the meningococcal immunization (Menomune/Menactra) within the past 10 years. Date \_\_\_\_\_
- read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will NOT obtain immunization against meningococcal meningitis disease. I understand that I may choose to seek vaccination in the future. The vaccine is available at the University Health Service for a fee and may also be available from community health providers or county health departments.

Student Signature \_\_\_\_\_  
(Parent/Guardian if under 18)

Date \_\_\_\_\_

#### Tetanus:

- Date of last combination Tetanus Toxoid and Diphtheria Toxoid:  Td or  Tdap Date \_\_\_\_\_  
(Must be within 10 years)

#### Rubeola (Measles) - complete one of the following:

- Immunization Dates: 1. Date administered: \_\_\_\_\_ 2. Date administered: \_\_\_\_\_
- Titer Date: \_\_\_\_\_ Results:  Positive  Negative (upload lab results)

#### Mumps - complete one of the following:

- Immunization Dates: 1. Date administered: \_\_\_\_\_ 2. Date administered: \_\_\_\_\_
- Titer Date: \_\_\_\_\_ Results:  Positive  Negative (upload lab results)

#### Rubella (German measles) - complete one of the following:

- Immunization Date: 1. Date administered: \_\_\_\_\_
- Titer Date: \_\_\_\_\_ Results:  Positive  Negative (upload lab results)

#### Varicella (Chicken Pox) - complete one of the following:

- Immunization Dates: 1. Date administered: \_\_\_\_\_ 2. Date administered: \_\_\_\_\_
- Titer Date: \_\_\_\_\_ Results:  Positive  Negative (upload lab results)
- Health Care Provider written diagnosis of chicken pox or herpes zoster Date of disease: \_\_\_\_\_  
(month/date/year)

#### Hepatitis B (Required) – complete one of the following:

- Immunization Dates: Dose 1. Date: \_\_\_\_\_ Dose 2. Date: \_\_\_\_\_ Dose 3. Date: \_\_\_\_\_  
(Second and third dose should be administered not less than 1 and 6 months, respectively, after the first dose)
- Declination form

Signature of NP/PA/Physician \_\_\_\_\_ Date \_\_\_\_\_  
(Acknowledging review of student's immunization record)

**Tuberculosis Screen**

**IMPORTANT:** Students who have documented proof of receiving the BCG vaccine, chest x-ray, Quantiferon Gold or t-spot test must complete this form annually.

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

PPD History: \_\_\_\_\_

<b>Do you have or have you had any of the following?</b>	<b>Yes</b>	<b>No</b>
Chronic Renal Failure		
Immunosuppression		
Diabetes Mellitus		
Blood/lymph disease (i.e. Leukemia, Hodgkin's, Cancer)		
Silicosis		
Gastrectomy		
Jejunioileal Bypass		

<b>Are you taking:</b>	<b>Yes</b>	<b>No</b>	<b>If yes, explain</b>
Corticosteroids (prednisone, cortisone)?			
Immunosuppressive drugs?			

<b>Do you have any of the following symptoms?</b>	<b>Yes</b>	<b>No</b>	<b>If yes, explain</b>
Fever (unexplained, persisting more than two weeks)			
Night Sweats (for more than two weeks)			
Unexplained weight loss (5 lbs.)			
Cough (persisting longer than 3 weeks)			
Blood-tinged phlegm (anytime)			

If I (student) develop any of the above symptoms during the course of the academic year, I will immediately notify the Clinical Site Coordinator.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Confidentiality Agreement

**IMPORTANT:** Please read all sections. If you have any questions, please seek clarification before signing.

### Confidentiality of Patient Information

I understand and acknowledge that:

1. Services provided to patients are private and confidential.
2. Patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary.
3. All personally identifiable information provided by patients or regarding medical services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure.
4. In the course of my employment/affiliation with the Decker School of Nursing, I may be given access to certain Confidential Information.

### Confidentiality of Decker School of Nursing Information

I understand and acknowledge that information discussed in any Decker School of Nursing committee is confidential.

### Disclosure, Use and Access

I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including but not limited to co-workers, friends and family members). I understand that this obligation remains in full force during the entire term of my employment/affiliation and continues in effect after such employment/affiliation terminates.

### Confidentiality Policy

I agree that I will comply with confidentiality policies that apply to me as a result of my employment/affiliation.

### Return of Confidential Information

Upon the termination of my employment/affiliation for any reason, or at any other time upon request, I agree to promptly return to the Decker School of Nursing all copies of Confidential Information then in my possession or control (including all printed and electronic copies), unless retention is specifically required by law or regulation.

### Periodic Certification

I understand that I may be required to periodically certify that I have complied in all respects with this agreement, and I agree to so certify when requested.

### Remedies

I understand and acknowledge that:

1. The restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients, the Decker School of Nursing and affiliated clinical agencies.
2. My failure to comply with this Agreement in any respect could cause irreparable harm to patients, the Decker School of Nursing and affiliated clinical agencies for which there may be no adequate legal remedy. I therefore understand that the Decker School of Nursing or my employer may prevent me from violating this Agreement by any legal means available, in addition to disciplinary action(s) that may result in accordance with applicable Decker School of Nursing and Binghamton University policies and procedures.

Faculty       Staff       Student       Teaching/Research/Graduate Assistant       Employee

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_