CLINICAL REQUIREMENTS CHECKLIST

1. **Completed on CastleBranch:**
   - Select program and order eLearning tracker. Complete all modules.
   - 10-panel drug screen testing for: amphetamines, barbituates, benzodiazepines, cannabinoids, methadone, propoxphene, phencyclidine, opiates, methaqualone and cocaine.

2. **Completed at Health Care Provider’s Office:**
   Physical Exam*- The attached form must be signed.

3. **Completed at Health Care Provider’s Office OR separate documentation from Employee Health is provided:**
   Influenza*- To be completed between September 1-November 15.
   TB Skin Test*- PPD skin test or blood test is required. If PPD is positive, student has previous history of a positive tuberculin skin test or history of INH therapy, a chest X-ray is required within 12 months of starting the program.

4. **Additional Requirements:**
   Please upload the following to CastleBranch.
   - CPR Certification- American Heart Association, BLS for Healthcare Providers will only be accepted. Upload signed CPR card.
   - Active RN License (in the state your are a resident of)
   - Health Insurance
   - ACNP Students Only
     - ACLS Certification
     - One of the following specialty certifications - CCRN, PCCN, CEN or NEURO
       - Please note that this requirement does not need to be fulfilled until registration opens for the third semester
   - Nurse Anesthesia Students Only
     - ACLS and PALS Certification

*Denotes a clinical requirement to be updated annually.

For more information please visit: [http://nhs.georgetown.edu/nursing/resources/clearance/](http://nhs.georgetown.edu/nursing/resources/clearance/).
Georgetown University School of Nursing & Health Studies

Returning MS/DNAP Student
Health Screening Form
_____ Academic Year

Please login to your account at:
https://www.castlebranch.com/
to upload your completed form.

DEMOGRAPHIC INFORMATION | Completed by student. Please print. | THIS IS A REQUIRED SECTION |
| Last Name | First | MI | Age | Date of Birth | Country of Birth |
| GU ID Number | Home Phone Number | City | State | Zip Code |

Program (circle one): FNP ACNP ACNP/CNS NM/WHNP WHNP NE

PHYSICAL | Completed by the health care provider. | THIS IS A REQUIRED SECTION IF YOU ARE RENEWING YOUR PHYSICAL |
I have examined this patient, ________________________________, and he/she is in good health, adequate for participation in the clinical student nursing setting.

Signature: ____________________________________________
Health Care Provider
Date

TB TEST | Completed by health care provider. |
PPD Placed: _______________________
Mo/Day/Yr
PPD Read: ________________________ Negative / Positive
Mo/Day/Yr

If PPD is positive, or student has previous history of a positive tuberculin skin test, a chest X-ray is required within 12 months. An Annual Tuberculosis Screening Questionnaire must be completed and signed by a health care provider. Please visit http://nhs.georgetown.edu/students/graduate/forms to download the form.

Signature: ____________________________________________
Health Care Provider
Date

SEASONAL INFLUENZA VACCINE | Completed by the health care provider. |
Date of last dose received: _____ / _____ / ______
Lot # __________

Signature: ____________________________________________
Health Care Provider
Date