**School Letterhead**

**To: UC Davis Health - School Liaison**

Center for Professional Practice of Nursing

4900 Broadway, Suite 1630

 Sacramento, CA 95820

 (916) 734-9790

**Agency: UC Davis Health**

**From: Faculty Name or School Placement Coordinator Name** (individual submitting this attestation letter)

School name/Address/Contact phone number

**Re:** Compliance of Clinical Requirements

**Date: Today’s Date**

**Semester / Dates of Rotation: Semester / Start Date – End Date**

**Number of hours: Total Hours**

**Program: Degree Program**

**Course Name: Course Code and Name**

**Assigned Faculty Name / Contact: Academic faculty Name. Phone Number, and Email**

**Agency: School Name**

**Days of Week / Times: Schedule for Clinical Rotation**

This letter refers to the specific needs for student/faculty compliance with UCD Health and BRN regulatory requirements at agencies where nursing students are placed. This includes faculty approval by the BRN for units in which they supervise students. Documentation is available from the School of Nursing and will be made available within 2 hours of request from UCD Health or delegate by contacting: **Name and phone number(s)/e-mail of one designated staff member to get student documentation**

The students and faculty have met the following requirements, allowing them to participate fully in the clinical component:

* Student / Faculty Name Badge
* Medical Clearance
* Malpractice Insurance & Liability
* Personal Health Insurance
* Criminal Background Check – all names and counties for the past seven years for: SSN trace, felony/misdemeanor conviction, sex offender, DHHS/OIG cumulative sanction, GSA excluded Party/Debarment
* Drug Screening
* CPR Certification per American Heart Association (AHA)
* Tuberculosis clearance/screening – initial clearance is determined by a negative Quantiferon completed within 90 days of start date (preferred method) or negative 2-step PPD surveillance. 1st PPD within 365 days and a 2nd PPD within 90 days of start date. If already Quantiferon positive or PPD positive, a negative chest x-ray report and negative healthcare provider reviewed/administered symptom interview/questionnaire within 90 days of start date. A negative Quantiferon or one step PPD is required annually thereafter.
* Immunizations
	+ MMR: immunizations or titer
	+ Hepatitis B: vaccination, titer, or declination
	+ Varicella: immunizations or titer
	+ Tdap: vaccination or declination
	+ Influenza: vaccination or declination (September – April)
	+ Hepatitis C antibody titer baseline recommended
	+ COVID-19: full vaccination (14 days after final dose in the series) or documented exemption
		- If an exemption exists, antigen or PCR testing is required
	+ COVID-19 booster
		- Pfizer or Moderna – 5 months after 2nd dose
		- J&J – 2 months after 1st dose
		- If not yet eligible to receive the COVID-19 booster, the booster must be completed within 14 days of becoming eligible; otherwise, antigen or PCR testing is required, and medical or religious exemption should be on record
* Agency Specific Clinical Requirements (if requested)
	+ Car Insurance
	+ Fingerprinting
* HealthStream Modules – at program entry and annually thereafter
	+ Rapid Regulatory Compliance: Clinical I
	+ Rapid Regulatory Compliance: Clinical II
	+ Hazardous Communication
	+ HIPAA
	+ Blood Borne Pathogen Education

Attachments with specific information regarding rotation:

* Course Objectives
* Skills Checklist with level of supervision
* Student Contact Information
* Student Rotation Schedule

All faculty and students, vaccinated and exempted, will follow PPE guidelines and testing requirements as currently required based on their vaccination status. It will be the responsibility of the School of Nursing to ensure that all students and faculty are following current PPE and testing guidelines while at UCD Health.

Please contact clinical faculty for immediate concerns and/or questions. Please do not hesitate to contact us with the same.

As always, we appreciate your support and development of students and preparing them for professional practice.

Sincerely,

**School Signature**

The following Students/Faculty have met all immunization/attestation requirements.

Student(s) Contact Information (see attached emergency contact list):

|  |  |  |
| --- | --- | --- |
| **Student/Faculty Name** | **Student/Faculty Phone Contact Number** | **Student/Faculty Email** |
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The following Student(s)/Faculty are **NOT** COVID-19 vaccinated due to medical or religious exemptions.

Student(s) Contact Information (see attached emergency contact list):

|  |  |  |
| --- | --- | --- |
| **Student/Faculty Name** | **Student/Faculty Phone Contact Number** | **Student/Faculty Email** |
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