College of Staten Island
The City University of New York
Health & Wellness Services

HEALTH CENTER

1C-Room112
719.982.3045
healthcenter@csi.cuny.edu

Students accepted to the Nursing Program are required to submit a completed physical with associated labs each semester to the Health Center for review and clearance. Physical exams and clearance have very strict windows of opportunity in which the exams need to be performed and clearance obtained. For Fall 2021, annual exams, required tests and clearance need to occur between June 1st and July 29th 2021.

Getting the physical and labs may take time! Reviewing and clearing the physical, including lab test results may require several follow-up visits to complete. It is advisable to make an appointment with your PCP early. Physical exams done by the Health Center nurse practitioner are **free** (*see below for more information)**.** Make your appointment now.

Accurate completion of the physical form is your responsibility! Please review your physical form before leaving your healthcare provider's office. **Make sure all fields are filled out completely and correctly.**

REQUIRED INFORMATION ON THE FORM INCLUDES:

- **Tuberculosis Screening- PPD and/or Quantiferon** - must submit **one** of the below:
  - A negative PPD (TST-tuberculin skin test)
  - A positive PPD or history of positive PPD with negative chest x-ray (*attach copy of x-ray report within 5 years*)
  - A negative Quantiferon test (*attach copy of lab report)*
  - A positive Quantiferon result requires a follow up negative chest x-ray *(attach copy of x-ray report within 5 years)*
- **Tdap -** Must be within 10 years. **Tdap may not expire during the semester**
- **Flu** – Must be current seasonal flu vaccine. Proof of vaccination with lot number is required if obtained at Pharmacy.
- **Varicella** - A titer value (number) that constitutes immunity OR 2 vaccination dates 28 days apart *(attach copy of lab report)*
- **Measles, Mumps and Rubella –** A titer value (number) that constitutes immunity OR 2 vaccination dates 28 days apart *(attach copy of lab report)*
- **Hepatitis B**
  - Hepatitis B surface antibody titer is strongly recommended to verify immunity, but may be declined
  - Documentation of 3 doses of hepatitis B is acceptable
  - You do not need to have all three doses of hepatitis B to be considered for the program
- **Urine drug screen (UDS)**
  - UDS – ***done by Castle Branch only: https://portal.castlebranch.com/uz86***
  - ***A copy of the UDS lab results must be submitted with the nursing physical form.***
  - **PLEASE NOTE:** All positive UDS results will be reported to the Nursing Department.

PLEASE NOTE: Equivocal/Negative titers are NOT accepted*. Titers must be positive/reactive. If titers are equivocal or negative, proof of the appropriate vaccination/s must be provided.*

The healthcare provider must SIGN, STAMP and DATE PAGE 2 of the physical form.

***Health Center Physical:** If you would like to have your nursing physical done with the Health Center nurse practitioner via telehealth, please make **an appointment** by emailing: healthcenter@csi.cuny.edu. There is no charge for the physical. If you do not have health insurance, lab tests can be done at a LabCorp Service Center at a reduced fee.

Submission: Email completed nursing physical form with a copy of the UDS lab results to the Health Center at **healthcenter@csi.cuny.edu** in **PDF format** or upload via CUNYfirst and send upload notification email to the Health Center.

Thank you for your cooperation.

Revised 3/4/2021

PHYSICAL EXAMINATION

College of Staten Island The City University of New York Health & Wellness Services	**Health & Wellness Services** **2800 Victory Blvd, 1C, Room 112** **Staten Island, NY 10314**	**Telephone 1.718.982.3045** **Fax 1.718.982.2966** **TTY 1.718.982.3315**

Last Name **First Name**

Address **City** **State** **Zip code**

Date of Birth **EMPL ID #** **Phone #**

Physical Examination

Prior to clinical assignment, all students must have a complete annual physical exam and recorded medical history. The examination shall be of sufficient scope to ensure that the student is free from any health impairment that is a potential risk to patients or which may interfere with performance of their duties.

Please provide the following required documentation:

TEST	RESULT
TUBERCULOSIS SCREENING **(PPD or Quantiferon)**	**PPD** DATE_____NEGATIVE_____POSITIVE _____ IF POSITIVE, DATE OF CHEST X-RAY _____ CXR RESULTS_____(**Attach copy of CXR report)**
	QUANTIFERON DATE_____ NEGATIVE_____INDETERM_____POSITIVE _____ (**Attach copy of lab report)** IF POSITIVE, DATE OF CHEST X-RAY _____ CXR RESULTS_____(**Attach copy of CXR report)**
Tdap BOOSTER **(must be within last 10 years)**	DATE OF LAST Tdap BOOSTER _____
FLU VACCINE	DATE OF FLU IMMUNIZATION _____
VARICELLA VACCINE 1. _____ 2._____OR	TITER VALUE DOES THIS TITER CONSTITUTE IMMUNITY TO VARICELLA? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**

Last Name **First Name** **Date of Birth**

TEST	RESULT
MEASLES VACCINE 1. _____ 2._____ OR	TITER VALUE_____DOES THIS TITER CONSTITUTE IMMUNITY TO MEASLES? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
MUMPS VACCINE 1. _____ 2._____ OR	TITER VALUE_____DOES THIS TITER CONSTITUTE IMMUNITY TO MUMPS? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
RUBELLA VACCINE 1. _____ 2._____ OR	TITER VALUE_____DOES THIS TITER CONSTITUTE IMMUNITY TO RUBELLA? □ **YES** □ **NO** **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
(***or***) MMR VACCINE	1._____ 2. _____
HEPATITIS B VACCINE 1. _____ 2. _____ 3. _____	See table below; **Equivocal/Negative titers not accepted (Attach copy of Lab Report)**
CASTLE BRANCH URINE DRUG SCREEN	DATE TESTED_____RESULT _____ **(Attach Copy of Lab Report)**

	TITER VALUE	**NEGATIVE**	**EQUIVOCAL**	**POSITIVE**
HbsAg				
HbcAB				
HbsAB				

I certify that the above student has had a complete physical examination and risk assessment that is of sufficient scope to ensure that the student is free from any health impairment which is of potential risk to patients or which may interfere with their performance. As such, this student is cleared to participate in clinical rotations at a hospital, nursing home, community or private health facility supervised by the College of Staten Island's Nursing Program faculty.

Health Care Provider's Name and Title **Date of Clearance**

Address **Telephone Number**

Health Care Provider's Signature and Stamp