

## Clinical Sciences Application Form for Clinical Placements

Date Received: (and/or reactivated)  
\_\_\_\_\_

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

Practicum Type	Indicate Year		Practicum Type	Indicate Year	
	Summer/Fall	Winter/Spring		Summer/Fall	Winter/Spring
Phlebotomy			Cytogenetics		
Clinical Assistant			Molecular Biology		
CLT			Partial Practicum		
CLS-Generalist			Surgical Technology*		
CLS-Microbiology					

Campus Address \_\_\_\_\_

Phone: \_\_\_\_\_

Home Address \_\_\_\_\_

Phone: \_\_\_\_\_

**DEADLINE:**  
December 10 and April 10  
for Summer/Fall and Winter/Spring  
practicum respectively.  
\*ST deadlines are May 10 and  
October 10 for August and January  
practicum respectively.

1. List the names of your references below. (Preferably a former employer and one college science instructor – other than CS faculty).

	Name	Phone	Address/Department
a.	_____	_____	_____
b.	_____	_____	_____

2. If you hold certification credentials in the health field, please indicate:  
Type and date of certification \_\_\_\_\_
3. Please describe any work experience that may relate to this career interest. (Give name of employer, job description, length of employment, reason for leaving. Use back of page or separate sheet).
4. Why are you pursuing this career interest? (Use back of page or separate sheet).

**Northern Michigan University • School of Clinical Sciences**  
**VERIFICATION OF IMMUNIZATION AND HEALTH STATUS FOR CLINICAL PLACEMENT**

Part I (To be submitted with application)

NAME: \_\_\_\_\_  
 (Last) (First) (Middle Initial) (Date of Birth)

ADDRESS: \_\_\_\_\_

APPLICATION REQUIREMENTS:

For the protection of patients, students, and employees, the School of Clinical Sciences requires that students document the following before their clinical experience:

- Tuberculin test in the past six months
- Varicella, rubella, and rubeola immunity
- Up-to-date diphtheria and tetanus shots
- Hepatitis B vaccination or signed declination
- Annual influenza or signed declination

MEASLES	Two immunizations after 12 months of age _____ Date _____ Date
	OR Documentation of disease by physician OR Titer results indicating immunity OR One immunization of MMR after 1989 _____ Date
RUBELLA	Immunization after 12 months of age. _____ Date OR Documentation of disease by physician OR Titer results indicating immunity
HEPATITIS B	Vaccine series completed _____ Date OR Signed declination
TETANUS/DIPHtheria PERTUSSIS	Vaccination _____ Date Tdap _____ Date (within 10 years?)
VARICELLA	Have you had chicken pox? Yes - Titer results indicating immunity required No - Evidence of two doses of Varivax required

\_\_\_\_\_  
 Signature\* Date

**\*This form must be signed by a physician, nurse practitioner, registered nurse, or other licensed health official.**

Baseline Eye Exam (For Surgical Technology Students) – Submit a copy of exam results

\_\_\_\_\_  
 Signature by Optician/Optomtrist Date

ADDITIONAL INFORMATION: (To Be Completed by Associate Dean and Director, School of Clinical Sciences)

1. Professional/Student liability insurance coverage: Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, company and policy number: \_\_\_\_\_
2. The student has been educated in universal precautions at the University regarding the appropriate handling of blood, tissue, and body fluids. However, it is expected that students will participate in the clinical agency's orientation and safety program at the beginning of the practicum.

\_\_\_\_\_  
 Signature

**Northern Michigan University • School of Clinical Sciences**  
**VERIFICATION OF IMMUNIZATION AND HEALTH STATUS FOR CLINICAL PLACEMENT**

Part II (To be submitted within 6 months of placement)

NAME: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Date of Birth)

ADDRESS: \_\_\_\_\_

INFLUENZA Immunization \_\_\_\_\_ Date  
To be obtained in current fall season



\_\_\_\_\_  
Signature\* Date

**\*This form must be signed by a physician, nurse practitioner, registered nurse, or other licensed health official.**

TUBERCULIN TEST Negative TB Test \_\_\_\_\_ Date (within 6 months prior to placement)  
OR Negative Chest X-Ray \_\_\_\_\_ Date



\_\_\_\_\_  
Signature\* Date

**\*This form must be signed by a physician, nurse practitioner, registered nurse, or other licensed health official.**

HEALTH INSURANCE:

Company and policy number: \_\_\_\_\_

You may also be required to complete drug screening and finger printing dependent upon your clinical placement site.

NORTHERN MICHIGAN UNIVERSITY  
College of Professional Studies

**Hepatitis B Policy**

**Hepatitis B Policy Rationale**

Health science students are at risk for contacting Hepatitis B because they are often exposed to blood and body fluids during their clinical practice. According to the Center for Disease Control (CDC), between 15% and 25% of health care workers will contact hepatitis B during their careers. Your individual risk is directly related to how often you are exposed to blood and other body fluids.

Hepatitis B is a serious disease. Although 80% of those who contact acute hepatitis B do recover completely, about 1% of those who contact acute hepatitis B do not recover completely, about 1% of people who contact hepatitis B die of a fulminant infection. The remaining people who do not recover become carriers. About 25% of carriers go on to develop chronic active hepatitis that may progress to permanent liver damage. Carriers can transmit the virus to their babies in utero, and carriers run a high risk of developing primary liver cancer.

In view of the hazards associated with Hepatitis B, as cited by the Center for Disease Control (CDC), the College of Professional Studies at Northern Michigan University recommends that every student in its programs should consult with his or her personal physician or health care provider and seriously consider vaccination with the Recombivax HB vaccine prior to admission to his or her major. The CDC recommends vaccination for anyone frequently exposed to blood and other body fluids in the workplace. Serum derived from Heptavax B and the genetically engineered Recombivax HB are considered safe and effective by CDC. We are informed that between 90% and 96% of those who receive the full course of therapy (through injections) acquire immunity, which seems to be long term. As in the case with many infectious diseases and the use of vaccinations there is an element of risk and no assurance of full protection. You should inform yourself thoroughly and consult with your personal physician or health care provider. (January, 1992)

I acknowledge that I have read the College's rationale regarding Hepatitis B and Hepatitis B vaccines. My questions regarding this disease and the vaccines available have been satisfactorily answered. I shall assume full responsibility for consulting with a physician or health care provider on this matter.

I understand that receiving the vaccine is strongly recommended but is entirely voluntary and is not a condition for being a student in the College of Professional Studies. I also understand that, should I accept the vaccine, it is my responsibility to complete the series of three injections as recommended. The second injection in the series will be given one month after the first injection, and the final injection will be given six months from the first.

\_\_\_ I have already received a Hepatitis B vaccine and I will supply verification of this.

\_\_\_ I hereby request that I be given Recombivax HB vaccine. I understand that I must make arrangements for this at the NMU Health Center or other health care provider and that it is at my expense.

\_\_\_ I hereby decline the vaccine, and release the College of Professional Studies, all employees and Board members of the University of liability in the event that I become infected with the Hepatitis B virus.

I fully recognize the hazards in health care professions and hereby hold Northern Michigan University harmless from any liability resulting from its action in providing me with the information set forth in the Hepatitis B policy on this form and further hold the University harmless from any liability from my voluntary decision to be vaccinated or to decline to be vaccinated.

Student Name \_\_\_\_\_ Program \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Department of Clinical Sciences**  
**VERIFICATION OF POLICIES**

I have read the **Student Policy Manual**, have taken at least one CLS or ST course (as appropriate) or equivalent and **fully understand**:

1. The function/job description/duties of my clinical profession. I can meet these standards based on my existing skills and abilities or through the use of typical corrective devices (see surgical technology section for essential functions for that program). If I require reasonable accommodations I have contacted the ADA Office.

Essential Functions:

- Possess sufficient vision to easily read charts, graphs, instrument panels, printouts, small graduated scales, etc.
- Be able to discriminate colors in order to identify reagents, select proper tube types, distinguish physical properties of various body fluids and prepare and identify cells and tissues.
- Be able to read, write and communicate in the English language to facilitate effective communication with patients, physicians, and all other members of the health care team.
- Possess sufficient hearing ability with or without auditory aides to understand the normal speaking voice and discern audible instrument alert signals and timing devices.
- Demonstrate sufficient manual dexterity to safely and accurately perform required tasks such as: phlebotomy, operating delicate instruments, manipulating tools, handling small containers of potentially bio-hazardous specimens (one by one-half inch), and utilizing sample measuring devices.
- Be sufficiently mobile to traverse about the laboratory, hospital corridors, patient rooms, offices and patient examining rooms, (minimum width approximately three feet).
- Possess the emotional health and psychological stability required to fully utilize their intellectual abilities under stressful conditions thus allowing them to be able to recognize emergency situations, take appropriate action, and be an effective problem solver.
- Be able to sit for extended periods of time at computer stations, read information from a monitor, and use the keyboard.

2. The safety precautions;

3. That I am **required** to have health insurance coverage;

4. That I am **required** to obtain HBV vaccination;

5. The criteria for clinical site placement and application procedures;

6. That I must submit to a Criminal Background Check; if accepted for placement, see the Department Head for instructions;

7. That I am **required** to authorize release of all records and information pertaining to any convictions for criminal and other offenses/violations.

I hereby authorize the release of all records and information pertaining to any and all convictions for criminal offenses, ordinance violations or penalties for violation of University Regulations on file in the Dean of Students office of the University, at the Michigan State Police Central Records Division, the Public Safety Department of the University, or any other criminal justice agency concerning myself, and I hereby consent to the use of communication among the faculty and administration of the Clinical Sciences Department of records, information and evaluation materials pertaining to continuing in the Clinical Sciences Department at Northern Michigan University. In addition, I understand that I am responsible for notifying the director of the Clinical Sciences Department of any convictions between now and the completion of my CLS program.

Any questions that I may have had about the above Standards and policies have been answered by program faculty to my satisfaction.

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness Name \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Attach any documentation pertaining to the above requirements. This form must be submitted with clinical placement application.

**CONFIDENTIAL RECOMMENDATION CONCERNING**

School of Clinical Sciences  
College of Professional Studies  
Northern Michigan University  
West Science 3513  
Marquette, MI 49855  
(RETURN TO THE ABOVE ADDRESS)

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

Major \_\_\_\_\_ Graduation Date \_\_\_\_\_

**Basis for Rating Candidate**

\_\_\_\_\_ Employer  
\_\_\_\_\_ Professor

\_\_\_\_\_ Know candidate well  
\_\_\_\_\_ Limited knowledge of candidate  
\_\_\_\_\_ Do not remember candidate

The traits listed below are of importance to employers in selecting college graduates. Please rate this individual with respect to other students of comparable age and experience by PLACING A CIRCLE AROUND the number following each characteristic. Leave blank those characteristics which you have no basis for rating.

	<u>OUTSTANDING</u>		<u>AVERAGE</u>			<u>BELOW AVERAGE</u>	
1. PERSONALITY	1	2	3	4	5	6	7
2. ATTITUDE	1	2	3	4	5	6	7
3. MATURITY	1	2	3	4	5	6	7
4. ORIGINALITY AND INITIATIVE	1	2	3	4	5	6	7
5. MASTERY OF SUBJECT MATTER	1	2	3	4	5	6	7
6. DEPENDABILITY	1	2	3	4	5	6	7
7. WRITTEN EXPRESSION	1	2	3	4	5	6	7
8. ORAL EXPRESSION	1	2	3	4	5	6	7

GENERAL COMMENTS: (Please discuss any outstanding qualities, possible weaknesses or overall impression)

Rater's Signature \_\_\_\_\_  
Position \_\_\_\_\_  
Department \_\_\_\_\_  
Address \_\_\_\_\_

Rater's Name \_\_\_\_\_  
Organization \_\_\_\_\_  
Date \_\_\_\_\_

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Rater's Name \_\_\_\_\_  
 Organization \_\_\_\_\_  
 Date \_\_\_\_\_