Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

INDIVIDUAL STUDENT ORIENTATION VERIFICATION FORM

STUDENT INFORMATION

Student Full Name _____

Student Telephone # _____ Student Email _____

Current/Previous Kaiser Permanente Employee? ☐ No ☐ Yes: Location & Dept. _____

Emergency Contact _____ Relationship _____ Telephone # _____

SCHOOL AFFILIATE INFORMATION

Affiliated School _____ Program _____

Clinical Hours Needed _____ Start Date of Rotation: _____ End Date of Rotation: _____

Faculty/Designee Name _____ Telephone # _____

Faculty/Designee Email _____

PRECEPTOR INFORMATION

Preceptor Name _____ Department/Facility _____

Telephone # _____ Email _____

REQUIRED DOCUMENTATION

1.	**Course Syllabus & Objectives**	**Provide Copy**
2.	**Professional License & Certification Verification**	**Provide Copy** if applicable
3.	**BLS – ACLS – PALS – NRP**	**Provide Copy** (provide what you have)
4.	**Criminal Background Check**	**Provide Copy** Date: _____
5.	**Drug Test (10-panel including Tricyclic Antidepressants)**	**Provide Copy** Date: _____

REQUIRED HEALTH SCREENING (PROVIDE DATES ONLY; NO DOCUMENTATION NEEDED)

MMR Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**	
Varicella Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**	
Hepatitis B Positive Titer, 3 Immunizations, or Declination are **REQUIRED**	**Positive Titer Date:**	**Imm. #1 Date:**	**Imm. #2 Date:**	**Imm. #3 Date:**
Tuberculosis (TB) Positive TSTs are **REQUIRED** to provide a negative CXR report	**Last 12 Months:** **Result:** _____ mm	**Last 24 Months:** **Result:** _____ mm	**Negative Chest XRay Date:**	
Tdap	**Immunization Date:**			
Influenza (Flu) Vaccination **NO DECLINATIONS ARE ACCEPTED FOR ANY REASON**	**Immunization Date:**			
Hepatitis A (Dietary Students only)	**Immunization Date:**			

HEALTH SCREENING QUESTIONS	
Please answer the following questions:	
Do you have a condition that is currently infectious?	☐ No ☐ Yes, describe:
Have you had an unexplained weight loss in the last year?	☐ No ☐ Yes, amount lost:
Do you have a persistent cough lasting 3 weeks or more?	☐ No ☐ Yes
Do you cough up blood?	☐ No ☐ Yes
Do you have persistent, unexplained fevers or night sweats?	☐ No ☐ Yes
Do you have a rash?	☐ No ☐ Yes, for how long?
Have you seen a doctor for any of the above?	☐ No ☐ Yes, list which items:

REQUIRED READING (CONTENT AVAILABLE ON NURSING PATHWAYS WEBSITE)		
All Students:		**Nurses/Nursing Students Only:**
☐ Student unpaid field experience and training policies and procedures	☐ Situation, Background, Assessment, & Recommendation (SBAR)	☐ Regional High-Alert Medication Safety Practices Polices & Procedures
☐ Affiliated Schools Criminal Background Check/Drug screening policies and procedures	☐ Guide to the principles of responsibility	☐ KP Nursing Professional Practice Model
☐ Drug-Free Workplace National HR policy	☐ Dress Code	☐ KP Vision & Values
☐ Current Ambulatory/Inpatient National Patient Safety Goals	☐ Five Compliance Expectations	☐ What is the Professional Practice Model?
☐ HIPPA 101: Privacy and Security Basics	☐ Prevent Fraud, Waste, and Abuse	☐ **Inpatient:** Nurse Knowledge Exchange Plus (NKE+)
		☐ **Inpatient:** Barcoding Scanning Medication Administration – Instructions for Students

I hereby affirm that the information I provide during the Orientation Verification process is accurate and fairly represents my understanding of Orientation Requirements and my current health status. I understand that any misrepresentation, misstatement or omission during this process, whether intentional or not, shall constitute a breach of contract between myself and Kaiser Permanente. Any such misrepresentation, misstatement or omission, whether intentional or otherwise, may result in immediate suspension or termination of program participation with Kaiser Permanente. I understand my school may receive a copy of this completed form.

Student Name _____ Student Signature _____ Date _____

Faculty Name _____ Faculty Signature _____ Date _____

KP Academic Liaison Representative/Designee _____ Date _____