School of Clinical Sciences
Application Form for Clinical Placements

Date Received: (and/or reactivated) _____

Name: _____
Email: _____
IN #: _____

	Indicate Year			Indicate Year	
Practicum Type	Summer/Fall	Winter/Spring	Practicum Type	Summer/Fall	Winter/Spring
Phlebotomy			Cytogenetics		
Clinical Assistant			Molecular Biology		
CLT			DG Practicum		
CLS-Lab Medicine			Surgical Technology*		
CLS-Microbiology			Speech, Language & Hearing Sciences		

Local Address _____

_____

Phone: _____

Home Address _____

_____

Phone: _____

DEADLINE:
December 10 and **April 10** for Summer/Fall and Winter/Spring practicum respectively.

*__ST__ deadlines are **April 1** and **October 1** for August and January practicum respectively.

1. If you hold certification credentials in the health field, please indicate:
   Certification #: _____ Date Taken: _____

2. 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).

3. Why are you pursuing this career interest? (Use back of page or separate sheet).

This section will be completed by School of Clinical Sciences Staff following submission:

_____

Reviewed by Embedded Advisor (Sign and Date)

_____

Reviewed by Faculty Advisor (Sign and Date)

NORTHERN MICHIGAN UNIVERSITY

College of health Sciences and Professional Studies

Hepatitis B Policy

Hepatitis B Policy Rationale

According to the Centers for Disease Control (CDC) www.cdc.gov, health care personnel are among the high-risk groups for Hepatitis B infection. Health science students are at risk for infection caused by the Hepatitis B virus because they are often exposed to blood and body fluids during their clinical practice. Your individual risk is directly related to how often you are exposed to blood and other body fluids.

Hepatitis B is primarily a blood-borne pathogen with lower concentrations of virus found in semen, vaginal fluid, and saliva. Between 5% and 70% of Hepatitis B infections are asymptomatic, 20%-30% of those infected exhibit clinical jaundice followed by a benign resolution of the infection. Approximately 10% of infected individuals become chronic carriers of the virus for more than 6 months and have a higher risk of liver disease, including liver failure, liver cancer or cirrhosis.

In view of the hazards associated with Hepatitis B, as cited by the Centers for Disease Control, the College of Health Sciences and Professional Studies at Northern Michigan University recommends that every student in its programs consult with their 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 the genetically engineered Recombivax HB is considered safe and effective by CDC. 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.

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 Health Sciences and 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 or Heplisav 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 Health Sciences and 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 _____

School of Clinical Sciences
VERIFICATION OF POLICIES

I have read the **Student Policy Manual**, 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 using typical corrective devices (See essential functions each program in the Student Policy Manual). If I require reasonable accommodations, I have contacted the ADA Office.
2. The safety precautions.
3. That I am **required** to have health insurance coverage
4. That I am **required** to obtain all vaccinations including:
   TB Screening

   - A baseline TB screening, **using two-step**, TST process OR QuantiFERON-Gold bloodtest to test for infection with M. tuberculosis.
   - Anyone with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for Latent TB Infection (LTBI) or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by aclinician.

   Immunizations - Immunization status willbe verified for the following diseases asdetermined bythe most current recommendations from the CDC: Rubeola, Mumps, Rubella, Diphtheria, and Varicella. Immunity status may be determined by following acceptable methods established by the CDC.

   Acceptable methods for determining immunity are:

   - Rubeola (Measles): Two doses of a measles containing vaccine such as a MMR vaccine OR laboratory confirmation of disease.
   - Mumps: Two doses of a mumps containing vaccination such as a MMR vaccine OR laboratory confirmation of disease.
   - Rubella: One dose of a rubella containing vaccinations such as a MMR vaccine OR laboratory confirmation of disease.
   - Pertussis: A single adult dose of a Tdap vaccine. Td vaccination does not fulfill thisrequirement.
   - Varicella: Two doses of the Varicella vaccine OR laboratory confirmation of disease OR diagnosis of history of Varicella or Herpes zoster by a healthcare provider.
   - Hepatitis B: Recombivax HB Hepatitis B three-dose series vaccine, Heplisav two-dose series vaccine, laboratory confirmation of immunity, OR a signed declination.*
   - Influenza - Proof of vaccination for the current year by October 31 or first day of fluseason.
5. The criteria for clinical site placement and application procedures.
6. That I must submit a Drug Screening.
7. That I must submit to a Criminal Background Check.
8. 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 School of Clinical Sciences of records, information and evaluation materials pertaining to continuing in the School of Clinical Sciences at Northern Michigan University. In addition, I understand that I am responsible for notifying the director of the School of Clinical Sciences of any convictions between now and the completion of my program.

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

Name _____

Signature_____Date_____

Witness Name _____

Witness Signature_____Date_____

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

*If declination waiver is submitted without signed medical reasoning, your placement may be rescinded by the affiliate.