Dear Prospective Student,

Thank you for your interest in the RN Refresher program at Molloy College.

Enclosed you will find an application to participate in an innovative RN Refresher course sponsored jointly by Molloy College Continuing Education and Professional Development with clinical experience at local hospitals.

Master’s prepared faculty from Molloy College conducts classes and laboratory experiences. Lectures and clinical itineraries are given prior to course commencement. Attendance at all classroom and clinical sessions is expected for successful completion of the course.

Upon completion, a certificate will be awarded to those who meet attendance and performance requirements. Participants in the R.N. Refresher course are eligible for employment as an entry level staff nurse in an acute care facility.

**Class Information:**

a. Lecture and discussion will take place in a classroom.

b. Skills practice will take place in the Nursing Lab or classroom.

c. Students may wear comfortable street clothes to lectures.

d. Parking will be available in designated areas only.

e. Content will afford the non-working RN up-to-date information on health problems, new technology, and the current role expectations of the registered professional nurse.

f. Pharmacology Review will be included as part of the classroom curriculum.
Clinical Information:

1. Clinical experience (on medical or surgical units) includes responsibility for direct patient care, administration of medications, and charting.

2. Transition from classroom to patient care is facilitated by faculty supervision of small groups of students.

3. Evaluation of clinical performance will be done by clinical faculty and will serve as a resource for job references.

4. All students must attend clinical sessions in white uniform; a white top with white slacks or skirt and white shoes (plain white leather sneakers permissible).

5. Identification badges provided must be worn at all times to clinical.

6. Parking lot available – please observe regulations.

   Students must submit the following documents:

1. Current, valid registered nurse license registration for New York State.
2. Individual liability insurance. (see below for information)
3. Physical examination – must include immunizations and/or titers.
   **Note: copies of actual lab values on the laboratory letterhead are to be submitted – values cannot just be listed on the physical form.**
   (See attached checklist form)
4. Current CPR certification – American Heart Association Basic Life Support for the Healthcare Provider. Certification classes available at Molloy prior to start of class (separate fee). Call (516) 323-3550 for class information.

To assist you in meeting these requirements, the following information is provided:
Malpractice Insurance may be purchased from Nurses Services Organization by calling toll free, 1-800-247-1500 or go to: www.nso.com

The cost of the program is $2,100. A $1050.00 deposit is required at the time of registration. Class enrollment is limited so please send your application and deposit as soon as possible in order to assure a place in the course.

If you have any questions, please call Molloy College Continuing Education and Professional Studies at (516) 323-3555 or 3558.

Sincerely yours,

Kathleen Lapkowski, MS, RN
Associate Director for Nursing
Division of Continuing and Professional Studies
MOLLOY COLLEGE
Division of Continuing Education and Professional Studies
RN Refresher Program Application

RVC  □  Suffolk Center  □

Name_________________________________________ Home Phone (____)______________________
Address ______________________________________ Work Phone (____)______________________
City _______________________St. _____Zip ________ E-mail__________________________________
Best time to reach you________________________________

Basic Nursing Education

□ Diploma
□ Associate Degree
□ B.S. Degree

Name of School ___________________________________________ Graduation Date_______________________
R.N. License # __________________________________________
Expiration Date _______________________ Years of Nursing Experience _______________________
Last Date of Practice _______________________ Area of Practice _______________________________
Name of Employer _____________________________________________________________________________
Malpractice Policy # ________________________________
Physical Exam: ______________________________ Date ___________________________________

I certify that all information I have provided in this application is true and complete to the best of my
knowledge.

Signature ___________________________________ Date:__________________________________

A deposit of $1050.00 is required. Please make check payable to “Molloy College” and mail to:

R.N. Refresher Course-Attn: Kathleen Lapkowski, MS, RN
Continuing Education and Professional Studies
Molloy College
1000 Hempstead Avenue
Rockville Centre, New York 11571

Amount Enclosed __________________________________________________________________________

You may charge my:  Visa ___________ MasterCard_________________ Discover_____________________
Card # ___________________________________ Expiration Date _________________________________
MOLLOY COLLEGE
Division of Continuing Education and Professional Studies
RN Refresher Program Application

Please submit with Registration

Participant’s Biography

In the space below, please write a brief statement about yourself. We have included some questions that might help you.

- What can you tell us about yourself?
- What are your goals? (Personal or professional)
- Why are you taking this course?
- What will you do when you finish?
- What concerns you most about taking this program?
- What are some of the strengths you bring to this project?

To help you clarify areas of need and to allow us to facilitate meeting them, please check next to each of the following categories information you feel would be helpful.

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Medications</th>
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<tbody>
<tr>
<td>Cardio- Vascular</td>
<td>IV Therapy</td>
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<tr>
<td>Gastro-intestinal</td>
<td>Oncology</td>
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<td>Genito-Urinary</td>
<td>Ethics</td>
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<td>Musculoskeletal</td>
<td>Nursing Process</td>
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<tr>
<td>Endocrine</td>
<td>Legislation</td>
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Student Checklist

Physical (Please include :)

☐ Yearly physical exam (our form) by MD, Nurse Practitioner or Physician Assistant.

☐ Two Step Tuberculin Test (if positive copies of chest x-ray results).

☐ DT every ten years Diphtheria/Tetanus

☐ Evidence of Immunization: Measles, Mumps, Rubella, Chicken Pox (copy of lab report)

☐ Season Flu Vaccine

☐ Laboratory Print out of Results of Titres for:
  Rubella
  Rubeola
  Varicella
  Mumps

NB Equivocal results will require a repeat testing; values indicating non-immunity will require a vaccine for rubeola and rubella

☐ Waiver Signed
### History & Physical Form

Name_______________________________________ Home Phone (___) _____________________________

Address _____________________________________ Work Phone (___) _____________________________

City _______________________St. _____ Zip ______ E-mail ___________________________________

Physical Date: ________________________________

Requires Annually: (Must be done within 30 days of Physical)

**Two Step Tuberculin Test** (PPD intradermal only) Date ___________ Result: _____________

Date ___________ Result: _____________

*If positive*, then a Chest X-Ray Date ___________ Result: _____________

*Attach Lab Reports to this Form*

<table>
<thead>
<tr>
<th>Titre</th>
<th>Value</th>
<th>Date</th>
<th>Result</th>
<th>If Negative, Date Vaccine Administered</th>
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<tr>
<td>*Varicella</td>
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<td><em>Rubeola</em></td>
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<td><em>Mumps</em></td>
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Polio Tri-Valent Oral Series Date: _____________________  □ Flu Vaccine_________________

Diphtheria/Tetanus
(DT) Series Date: ___________________ Booster within ten years date: ____________________

**Hepatitis B Vaccine:**

1. Date ___________  3. Date ___________

2. Date ___________  Follow-up Titer ___________
   (Recommended)
I certify that (print name of student) ___________________________ is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual’s behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.

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<tr>
<th>Height:</th>
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<th>Vision:</th>
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**Allergies:** ________________________  **Provider Signature:** ________________________

**Illnesses:** ________________________  **Provider Signature:** ________________________

**Injuries:** ________________________  **Provider Signature:** ________________________

**Restriction on Activity:** ________________________  **Provider Signature:** ________________________

**Medications:** ________________________  **Provider Signature:** ________________________

**Disabilities:** ________________________  **Provider Signature:** ________________________

____________________________________  __________________________________
Name of MD, Nurse Practitioner or Physician Assistant (Stamp)  Signature

____________________________________  __________________________________
Address  Phone

Date: ___________
Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Name (Print) ________________________________________________

Student Signature ___________________________ Date __________________

Student Waiver of Health Records

I, the undersigned, authorize release of information from my Student Health Record to affiliating clinical agencies.

Please Sign Below:

Student Signature: ___________________________ Date: __________________