Molloy University

Division of Continuing Education and Professional Studies

OR Training Program Application

Name_____ Home Phone (____)_____

Address _____ Cell Phone (____)_____

City _____St. _____Zip _____

E-mail _____

Basic Nursing Education:

- ☐ Diploma
- ☐ Associate Degree
- ☐ B.S. Degree

Name of School _____ Graduation Date _____

R.N. License # _____ Expiration Date _____

Years of Nursing Experience_____ Area of Practice _____

Current 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: _____

Please either email this completed application to Luisa Quiambao at: lquiambao@molloy.edu or mail it to:

Continuing Education and Professional Studies
Molloy University
Attn: Luisa Quiambao
1000 Hempstead Avenue
Rockville Centre, New York 11571

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Division of Continuing Education and Professional Studies

Participant's Biography

In the space below, please write a brief statement about yourself and why you are interested in working in the Operating Room.

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Checklist

Physical (Please include :)

☐ ***NYS Professional RN License/Registration***

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

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

☐ DPT every ten years Diphtheria/Tetanus and Hepatitis Dates

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

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

☐ Seasonal Flu Vaccine

☐ Student Waiver Signed

☐ N95 Fit Test Certificate

☐ Malpractice Insurance

☐ AHA BLS for Healthcare Provider (Red Cross not permitted)

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History and Physical Form

Name_____

***Attach Lab Reports to this Form**

Titres	Value	Date	Result	If Negative, *Date Vaccine Administered*
* Rubella	_____	_____	_____	_____
* Varicella	_____	_____	_____	_____
* Rubeola	_____	_____	_____	_____
* Mumps	_____	_____	_____	_____

Polio Tri-Valent Oral Series Date: _____

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

**Hepatitis B Vaccine: 1. Date _____ 3. Date _____

2. Date _____ Follow-up Titres _____
(Recommended)

****Students are required to be immunized with Hepatitis B Vaccine prior to the beginning of clinical practice or must sign a Declination statement.**

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PPD FORM

Name_____

PPD STEP # 1

Date:_____ Time Given_____	Manufacturer:_____Dose:0.1ml Exp Date_____Lot#_____ Given by:_____
Must be read 48-72 hours later Date:_____ Time Read:_____	Results:_____mm Read by:_____

PPD STEP # 2 Second PPD Test (7-21 days after Step #1)

Date:_____ Time Given_____	Manufacturer:_____Dose:0.1ml Exp Date_____Lot#_____ Given by:_____
Must be read 48-72 hours later Date:_____ Time Read:_____	Results:_____mm Read by:_____

OR

- **Quantiferon TB Gold Result_____Lab sheet must be attached**

➢ Positive findings of all Tuberculosis Tests require a negative chest X-Ray Report. X-Ray report must be attached:

Date: _____Result_____

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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.

Height:	_____	Weight	_____	B.P.	_____	HCT:	_____
Vision:	_____	Hearing:	_____	HGB:	_____		
U/A	_____	WBC	_____	Diff:	_____		

Allergies:	_____	Provider Signature:	_____
Illnesses:	_____	Provider Signature:	_____
Injuries:	_____	Provider Signature:	_____
Restriction on Activity:	_____	Provider Signature:	_____
Medications:	_____	Provider Signature:	_____
**Disabilities:	_____	Provider Signature:	_____

** Students with disabilities are considered on an individual basis. Students must be able to meet program objectives.

_____ _____

Name of Physician (Stamp) Physician's Signature

_____

Address Phone

Date: _____

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Flu Vaccine Form

StudentName_____

Manufacturer of Vaccine_____

Lot Number of Vaccine_____

Dose Administered_____

Date Administered_____

Name of Health Care Provider_____
(Stamp is required)

Health Care Provider Signature_____

Address _____

Phone _____

Date: _____

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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: _____