Western Governors University Compliance Form
RN-BSN and MSN

Required Compliance Items for American Data Bank (ADB) Documentation

Submitted documentation must include the following items:

- ✓ Document is in a typed or printed format
- ✓ Document lists name of provider
- ✓ Document lists student name
- ✓ Document lists service name
- ✓ Document lists service date
- ✓ Result with quantitative reference range and/or full interpretation of reading
- ✓ If document has a field which indicates a provider signature, document must reflect a provider signature or signature stamp

Please do not send any personal health records to WGU, as WGU cannot accept or store personal health information in accordance with HIPAA regulations. All compliance documentation must be submitted to the ADB.

Instructions for entering your immunization record

1. **MMR (Measles, Mumps, and Rubella):** Two (2) doses of MMR or serological evidence of MMR immunity via an IgG antibody titer screening.

2. **Tetanus Diphtheria and acellular Pertussis (Tdap):** Update upon expiration; you must have a tetanus, diphtheria, and acellular pertussis vaccination within the last ten years.

3. **Varicella:** Two (2) doses of varicella or serological evidence of varicella immunity via an IgG antibody titer screening.

4. **Influenza vaccine:** A seasonal flu vaccination is required an annual basis. Declining the flu shot may preclude you from being able to attend a field placement. If you choose to decline the flu shot, you must complete a WGU exemption form. To obtain this form please contact Health Placement Team.

5. **Tuberculosis (TB):** Annual submission; you must have documentation of a current tuberculosis screening every year while at WGU. **Acceptable TB testing includes either a, b, or c:**
   a) Annual PPD TB screenings
   b) Annual IRGA (QuantiFERON Gold or T-spot) blood TB test
   c) **If you have a Positive PPD:** You must supply printed proof of the date you tested positive, a Chest X-Ray (every two years) AND a TB Screening Report (Annually-see form

below) from your provider. This report must state that you, the patient, are 'negative' for signs and symptoms of tuberculosis.

6. **Hepatitis B:** Three (3) doses of hepatitis B or serological evidence of hepatitis B immunity via an IgG antibody titer screening.

7. **CPR Certification:** Expires every two years. You must have a current American Heart Association (AHA) Basic Life Support (BLS) CPR Certification. Please enter the date issued and submit a copy of the front and back of your CPR card to your compliance account.

8. **Registered Nurse (RN) License:** Update upon expiration; typically, every two years. You must have a valid RN license on file before the beginning of your Field Experience. Please enter the expiration date and submit a copy of your license to your compliance account. You can obtain the documentation for your RN license from Nursys online Service. The website address is, https://www.nursys.com. Please submit a screenshot to validate your current RN license.

9. **Health Insurance:** Update upon expiration; typically, annually. You must show evidence of health insurance coverage for the RN-BSN and MSN programs. Please enter the submission date and submit a copy of the front and back of your card to your compliance account.

10. **Physical Exam:** This is an additional item depending on the specific requirements for your host site. If required, you will need to submit a physical exam within the last year using the WGU form provided for you. Have your provider review and sign the form, certifying you are cleared for placement within a healthcare setting. (See the form below)

11. **Drug Screening:** This is an additional item depending on the specific requirements for your host site. To complete this item, you will need to order a drug screening through ADB.

12. **Background Check:** The background check you completed upon admission to WGU is valid for two years and must remain current throughout your entire program. If your background check is more than two years old, you will need to purchase a new background check through ADB to meet the compliance requirements at the time of your placement.

13. **Additional Site Requirements**: Depending on your chosen health site, your site can have additional site requirements. Your placement specialist will reach out to you with any additional requirements that may be required.

****Please contact a member of the Health Placement Team at CLPScompliance@wgu.edu with questions or concerns****

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WGU Annual TB Screening Form

Annual Health Screening Questionnaire for History of Positive TB Skin Test

Instructions: Annual symptom screening is required for all students who have a history of a positive tuberculosis (TB) test. Students are required to complete this form yearly ***only*** *if they have a history of a positive TB test.*

When did you have a positive TB test? ____

What is the date of your last chest x-ray? ____

Result:____

Do you CURRENTLY have symptoms of any of the following:

	YES	NO
Weight loss (unrelated to dieting)	☐	☐
Loss of appetite for >2 weeks	☐	☐
Bloody sputum	☐	☐
Night sweats/fever	☐	☐
Unusual fatigue for > 2 weeks	☐	☐
Persistent cough > 2 weeks	☐	☐

Answering "yes" to any of the above questions constitutes a positive screening evaluation and requires further follow-up with your Health Care Provider.

I am aware that misrepresentation of health information may result in dismissal from the program. I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Student Signature: ____________________________ Student ID Number: ________________________

Student Name (Print Name): ________________________________ Date: ________________________

Health Care Provider Declaration I declare I have completed a tuberculosis symptoms review on this student. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in the state of ______________________________________.		
X	**X**	
Licensed Health Care Provider Name (Print)	**Licensed Health Care Provider Signature**	**Date**
☐ **MD** ☐ **ND** ☐ **DO** ☐ **ARNP** ☐ **PA**	**Provider License #**	

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Physical Examination

As part of your program, you must have a licensed MD, ND, DO, ARNP, or PA complete the form below and document that you can physically fulfill the essential job functions of a nursing or allied health professions student.

Student Name:				**Birth Date:**		
Gender:	Male	Female	Nonconforming	Transgender Male	Transgender Female	Decline to Answer
Height:				**Weight:**		
Vital Signs:	B/P		Pulse	R/R		Temp.
Vision:	OS	OD	OU	**Hearing:**	Right	Left

SYSTEM	Function WNL		
	Yes	No	Comment
General			
HEENT			
CV			
Pulmonary			
GI			
GU			
Neurological			
Integumentary			
Musculoskeletal			
Immune System			
Endocrine			
Mental Health			

FUNCTION	Ability to Perform		
	Yes	No	Comment
Able to work standing, sitting, bending, lifting			
Able to use all physical senses			
Able to perform fine motor skills			
Able to coordinate physical and mental activities to perform tasks or skills safely			
Able to verbally communicate in English			
Possess sound mental health			
Exhibits a disability that would interfere with the cognitive, physical, or sensate ability to function safely in patient care situations			

Health Care Practitioner Declaration
I declare I have completed a Physical Examination on this student. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in the state of ___________________________________.

X	**X**	
Licensed Health Care Practitioner Name (Print)	**Licensed Health Care Practitioner Signature**	**Date**
☐ **MD** ☐ **ND** ☐ **DO** ☐ **ARNP** ☐ **PA**	**Practitioner License #**	