ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

CLINICAL ROTATION REQUIREMENTS ATTESTATION FORM

This form must be completed and submitted 2 weeks prior to **each** clinical rotation.

SCHOOL: _____ Program type (circle): MS/N ELM BSN ADN LVN Other

Clinical Instructor: _____ Email: _____ Phone: _____

CLINICAL EXPERIENCE dates: from _____ to _____ Preceptorship Required Hours: _____

DAY(S) OF THE WEEK: _____ TIME/SHIFT: _____ UNIT(S): _____ NUMBER OF STUDENTS IN COHORT: _____

MANDATORY – School Clinical Instructor/Coordinator must read and sign:

1. I have confirmed that all participants have on file at school, current (and valid for the duration of the clinical experience) and will be able to produce copies of these requirements for the Facility within 48 hours of the request:
   - ✓ *Cleared criminal background check*
   - ✓ *Immunization status for MMR, Varicella, TB clearance, TB Symptom Review letter if +PPD, COVID-19, and the strongly recommended Hepatitis B*
   - ✓ *Influenza seasonal vaccination December through March or declination form #received_____ #not received_____*

2. I verify (and have verification on file) that, prior to the first day of the clinical rotation, all listed students and clinical instructors have
   - ✓ *Completed all mandatory requirements including the ZSFG online hospital orientation module within the past 12 months.*
   - ✓ *Received site-specific orientation materials and understand the need to comply with all hospital policies, protocols, guidelines/standards*
   - ✓ *Students will complete the HIPAA/Confidentiality Agreement and Unit Orientation prior to being assigned to patient care.*
   - ✓ *Students have registered or completed training for the site's electronic health record where available.*

By signing below, I verify that I am able to produce documentation of any and all of the above upon request.

Print Name _____ Signature _____ Date _____

Faculty/Instruction Declaration

I certify that the information provided on this form is true, accurate and complete. I agree to provide the immunization/screening records upon the hospital's request. I understand that any false information will cause my disqualification in any programs on the Zuckerberg San Francisco General Hospital (ZSFG) campus and affiliated clinics. I recognize that all confidential information obtained or observed at SFGH is in confidential nature. I agree, at all times, to ensure the confidentially of all sensitive information I have contact with, comply with applicable laws and maintain patient privacy. I understand that failure to comply with any of the above requirements may result in cancellation of my instruction agreement. I further attest that I have received appropriate written material and introduced to the hospital and the appropriate department/unit/clinic protocol and standards. Signature: _____ Date: _____

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ZSFG Nursing Student Health Requirements		
Infectious Disease Immunization Health Requirements	**Also known as**	**Record keeping and other pertinent information**
Measles	Rubeola	Document date of titer result or vaccination
Mumps		Document date of titer result or vaccination
Rubella	German Measles or 3-day measles	Document date of titer result or vaccination
Varicella	Chicken pox	Document date of titer result or vaccination
Influenza	Seasonal Flu	1. Must receive vaccination annually. Document vaccination date. 2. Seasonal flu vaccination required annually from December through April. If the ZSFG infection control program extends or changes the season dates at ZSFG, the school will be notified
Tuberculosis	**TB**	
TB Option 1: To be completed by those students who have ***not*** had any TB skin testing within the past 13 months.	TB	1. Student to have TB two-step skin test screening performed. Documentation of both dates with negative results. 2. Screening with TB skin test annually thereafter. Documentation of annual negative TB skin test. 3. TB skin test to be repeated if student has been exposed to TB since last results.
TB Option 2: To be completed by those students who have had negative TB skin test results annually	TB	1. Record of the initial TB two-step results on file. 2. Student to have annual TB skin test screening. Documentation of annual negative TB skin test 3. TB skin test to be repeated if student has been exposed to TB since last results. NOTE: Quantiferon-TB Gold blood test result is only acceptable as a substitute for TB skin testing if Quantiferon results are within the last 14 months
TB Option 3: To be completed by those students who have had positive TB skin test results with negative chest x-ray OR have been vaccinated for TB	TB	1. Chest x-ray date to assess for active TB within the past 2 years ***and*** 2. Documentation of an annual TB symptom review by student's health care provider written on official medical center letterhead that the student does not have signs and symptoms of TB including: drenching night sweats, persistent fever, unexplained fatigue, unexplained weight loss, unexplained loss of appetite, swollen glands, shortness of breath, persistent coughing, coughing up blood and hoarseness.
COVID - 19	COVID	Document Date of Vaccinations. Health Order No. 2023-02, personnel in designated healthcare facilities and jails must receive either: 1. The initial series of vaccinations plus at least any one booster dose or 2. A single dose of the current vaccine formulation
Not Required but strongly encouraged:		
Hepatitis B	Hep B	Documentation of vaccination dates or titer results not required but strongly encouraged.

Please return this form to ZSFGNursingStudentPlacements@sfdph.org. Thank you!

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Legal Full Name *(First, Middle Initial, Last)*	Best Contact Phone #	Address	School email
Instructor:			

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