

# UNM-GALLUP NURSING PROGRAM CLINICAL READINESS CHECKLIST

Student: \_\_\_\_\_ Date: \_\_\_\_\_

ITEM	DATE/VERIFYING INSTRUCTOR		
HIPAA MODULE			
OSHA/BLOODBORNE PATHOGENS MODULE			
CURRENT CPR American Heart Association – BLS Provider	Expiration Date:	Expiration Date:	
<b>IMMUNIZATIONS</b>			
ANNUAL 2-step PPD or IGRA blood test* (*US Renal requires a 2-step TST or IGRA test done within 1 year at the start of Level 3 semester.)	1 <sup>st</sup> PPD	2 <sup>nd</sup> PPD	CXr (as needed) Date: Results
	Date: Date: Results:	Date: Date: Results:	
	IGRA blood test 1 <sup>st</sup> year Date: 2 <sup>nd</sup> year Date:		
MMR x 2 OR TITER	Date: Date:	Date: Titer results:	
<b>HEP B</b> (3 doses of Engergix-B, Recombivax or Twinrix <b>or</b> 2 doses of Heplisav-B) <b>OR TITER</b>	Date: Date: Date:	Date: Titer results:	
Tdap (Every 10 years)	Date:	Date:	
VARICELLA X 2 OR TITER	Date: Date:	Date: Titer results:	
ANNUAL PHYSICAL EXAM CLEARANCE ( <i>once a year starting from their first admission to the program and after significant health status change</i> )	Date:  Date:		
ANNUAL FLU VACCINE	Date:	Date:	
COVID-19 VACCINE	Dose 1 date: Product name: Clinic location		Dose 2 date: Product name: Clinic location:
	Dose 3 date: Product name: Clinic location		Dose 4 date: Product name: Clinic location:
	Other dose date: Product name: Clinic location:		Other dose date: Product name: Clinic location:

	Other dose date: Product name: Clinic location:	Other dose date: Product name: Clinic location:
CONFIDENTIALITY STATEMENT	Date:	
ANNUAL BACKGROUND CHECK	1 <sup>st</sup> year Date: 2 <sup>nd</sup> year Date:	
ANNUAL NURSING LIABILITY INSURANCE	Dates of coverage: Dates of coverage:	
DRUG SCREEN (for RMCH in Level 2)	Date:	
Instructor verification	Level 1: <input type="checkbox"/> Instructor/faculty initials: Level 2: <input type="checkbox"/> Instructor/faculty initials: Level 3: <input type="checkbox"/> Instructor/faculty initials: Level 4: <input type="checkbox"/> Instructor/faculty initials:	

Updated 1/10/2024-rjl