Ottawa University Nursing Program Student CEP Accountability Form

Must be completed Prior to Enrollment in First OU Course

Department: Nursing

Please read, sign and scan or fax documents to:

Cynthia Escagne- cynthia.escagne@ottawa.edu

Fax: 1-913-273-1700

Criminal Background Check

I understand that I am responsible for the costs of an updated criminal background check (*only* if an additional one is needed) by an *outside* facility if I conduct any observational experience and/or application-based project on their premises while in an Ottawa University nursing course. Furthermore, I give my permission for the University to release the results of this criminal background check, as well as information related to my health status form, to an outside facility in which I will observe or participate, if requested. Lastly, I understand that I am responsible for immediately notifying the Ottawa University Director of Nursing of any change in the status of my criminal record.

Standard Precautions and Student Health

I acknowledge the importance of using the Centers for Disease Control standard precautions for all potential physical and/or invasive contact that I may encounter as a student with clients, patients, or volunteers (who serve in the role of a patient/client for learning purposes).

I acknowledge responsibility for implementing and staying current with the Centers for Disease Control standard precautions to prevent the spread of infection. Lastly, I understand that I am responsible for any costs associated with my immunization, titers, and/or physical examination requirements, as well as any associated costs related to injuries and/or illnesses while acting in the capacity of a student in Ottawa University nursing courses.

Confidentiality Statement

I understand that during my capacity as an Ottawa University nursing student, I may have access to confidential information about clients, patients, patients' families, and other pertinent stakeholders involved in patient care. I understand I must maintain the confidentiality of all verbal, written, or electronic information relevant to clients' and patients' rights to privacy in all formats, including social media. And, under no circumstances can any medical record be removed from any institution. Therefore, I agree to adhere to the requirements of the Health Insurance Portability and Accountability Act (HIPPA). For additional information regarding HIPAA, please refer to: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

Student Information Notice

Because the University places a premium on student learning and is committed to ensuring high standards for student achievement, I am aware and understand that since I am ***concurrently*** enrolled in two separate nursing academic institutions, faculty of *both* institutions may need to share pertinent information about me in written form and/or verbal discussions. This information-sharing is necessary for my successful development as a professional nurse as well as my positive completion in both programs. I give my permission for faculty to discuss verbally and document in my advising records pertinent information regarding my clinical and academic performance (including review of transcripts), as well as any necessary professional student information while I am enrolled *within* the concurrent nursing program.

☐ **By checking this box and by signing below, I acknowledge that I have read, understand, agree and assume accountability for all the information stated above.**

Student Name (printed): _____

Student Signature: _____ Date: _____

Received by: _____ Date: _____