WALTERS STATE COMMUNITY COLLEGE

Print the NRSG 1620 and/or 1501 and/or 1340 Readmit Student Packet Fall 2025.

All paperwork must be completed and submitted to our office in its entirety the week of **July 28 -- August 1, 2025**. Our office hours are Monday-Friday 8am-4pm.

Packets must be submitted by deadline to maintain enrollment in the program for Fall 2025.

Instruction for Readmissions

- Complete steps 1 only if you have not maintained continuous enrollment or if your physical is more than 2 years old.
- Complete steps 2 and 3 if any requirements have expired, submit updated copies.
- Complete steps 4, 5, 6, 10, and 11
- Complete steps 7 and 8 if more than 1 year since previously completed or have not maintained continuous enrollment.
- Student ID photo date will be announced in eLearn.

Refer to e-learn for specific course requirements.

Please make sure you retain a copy of all documents submitted.

We will not be able to make copies after you submit your packet.

Thank you &
Congratulations!!!

NRSG 1620/1501/1340 (2nd Semester) – Med Surg I/Mental Health

READMIT STUDENT INFORMATION PACKET

Please read carefully (15 pages). Documents and money must be submitted by the indicated deadline.

	Complete all steps.	**DEADLINES**
Step 1	**Physical Form** Make your appointment date as soon as possible. ***Dates are important*** – Check the boxes when completed! Be sure your *Health Care Provider* has documented in ***all*** the spaces. ☐ Complete Physical form on both sides side 1 completed by student, side 2 completed by Health Care Provider ☐ 2-Step TB Skin Test with placement dates, reading dates, and results. First test is placed, read with 48-72 Student returns 1-3 weeks later for second placement. Second test is placed, read 48-72 hours later. After the initial 2-step TB skin test, students will complete an annual 1-step test. Chest x-ray (less than 3 months old) required if TB positive. ☐ Tetanus (TDAP) with date (must have been received within previous 10 years) ☐ (2) MMRs with date or rubella AND rubeola AND mumps titers that indicate immunity ☐ (3) Hepatitis B vaccine dates or Hepatitis B titer that indicates immunity ☐ (2)Varicella vaccine dates or Varicella titer that indicates immunity ☐ current season flu shot (student will submit flu shot annually as seasonal 2025-2026 flu shot becomes available) ☐ proof of COVID vaccine (if applicable) *If titers are drawn to show immunity, titer report listing results and immunity reference ranges must be submitted with the physical form. Contraindications for MMR, Hep B, or Varicella must be documented by Healthcare Provider** **PHYSICALS WILL BE CURRENT FOR 2 CALENDAR YEARS FROM THE DATE OF ADMINISTRATION BY THE HEALTH CARE PROVIDER AS LONG AS THE STUDENT MAINTAINS CONTINUOUS ENROLLMENT.**	**Student makes her/his appt.** **Health Care Provider must complete physical form.** **Submit July 28-Aug 1, 2025** ***Only applies if you have not maintained continuous enrollment or physical more than 2 years old.**
Step 2	**2025-2026 Season Flu Shot:** Students must receive the flu vaccine annually when it becomes available.	**When available**
Step 3	**CPR** – Submit copy of front/back of signed CPR Card. Completion card ***must*** be ***American Heart Association, BLS Provider.***	**Submit July 28-Aug 1**
Step 4	**Health Insurance Card**: Submit a copy of your current health insurance card. Due to clinical facility requirements, you must notify the health programs office should any health insurance coverage change during the program.	**Submit July 28-Aug 1**
Step 5	**Forms** - Please complete and/or sign: Flu shot Form, Consent Form, Student Conduct Form, HIPPA (Privacy agreement), Criminal Background form and Drug/Alcohol Abuse Policy, Verification of Health Insurance Form, Clinical Information Form (a portion of this info is in your handbook that you are required to read). Consent to Drug/Alcohol testing. All consent forms are valid for 2 calendar years from date signed unless student is readmitted.	**Submit July 28-Aug 1**
Step 6	**HESI Fee:** Payment is made online through HESI Elsevier E-commerce. **Payment ID** | **Payment Amount** | **Opens for Payment** 244375 | $137.38 | 8/17/2025	**Order online July 28-Aug 1**
Step 7	**Criminal Background Check:** A Truescreen criminal background check is required for participation in most clinical experiences. Students will be required to submit a clear background check to requesting clinical facilities. **The cost will be approximately $40.25.** Instructions for ordering your background check are included in this packet. .	**Order by July 28-Aug 1**
Step 8	**Drug Screen:** Most clinical agencies require drug screens. If you are required to complete a drug screen for your assigned clinical agency, you will be notified to do so prior to clinical orientation. ***Drug screens will be ordered through Truescreen***	**Further instructions following clinical placement**
Step 9	**Photo** - One (1) photo (candid shot from home is fine) with signature below it. No bigger than 4x6, please.	**Submit July 28-Aug 1**
Step 10	**Register for classes! –** Important course-specific data is available through eLearn once you have completed registration.	**Register immediately!**
Step 11	**MAKE A COPY OF ALL OF YOUR FILES FOR FUTURE REFERENCE!** Professional development implies that **YOU** maintain your personal records of the above.	**Make copies for yourself**

Criminal Background checks may be a requirement for training at some affiliated clinical sites. Based on the results of these checks, an affiliated clinical site may determine to not allow your presence at a facility. Additionally, a criminal background may preclude licensure or employment. If you are assigned to a clinical affiliate requiring a criminal background check, you will be required to provide the requested information. Acceptance of you as a student in the clinical facility will be at the clinical affiliate's discretion. As a student, you will be responsible for the cost of any required background checks. If a clinical affiliate denies your presence in the facility, you will not be able to complete the clinical/practicum and you will be withdrawn from the program. The specifications for the background check are at the discretion of the clinical affiliate. Should the affiliate not require a specific vendor for the check, the program director will provide a list of available vendors to purchase the required criminal background check. The cost of the criminal background check will average $50.00-$100.00. The exact amount may vary based on the affiliate specifications and individual student differences. As a student you will not be allowed access to a clinical facility for any student experience until the clinical facility has authorized your presence.

***** *Acceptance of you as a student in a clinical facility will be at the clinical affiliate's discretion. If a clinical affiliate denies your presence, you will not be able to complete the clinical\practicum and you will be withdrawn from the program*

Have questions? Call 423-585-6870. To assist us in allowing others into the program, please notify us if your plans change.

Student Background Investigation and Drug Screen Instructions

Student Name (printed):_____ Student ID Number: _____

Student Signature: _____ Date: _____

By my signature above, I acknowledge that I have received and read the information provided regarding the background check and drug screen. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from any Nursing Program faculty member or Program Director.

A background investigation and drug screen are requirements of the clinical agencies for your program of study. Failure to complete these requirements will prevent you from completing clinical rotations.

STEP 1: What to do if you need a Background Investigation?

Below are step-by-step instructions for accessing Application Station: Student Edition to authorize and pay for a background investigation.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. Enter the Code: **WSCCNURS185-CBC** in the Application Station Code field.
3. Click the "SIGN UP" button to create an account.
4. Follow the instructions on the Application Station web site.

Note – please store the username and password created for Application Station in a secure location. This information is needed to enter Application Station in the future which includes obtaining a copy of your background investigation report.

If you encounter issues with the Application Station: Student Edition or have questions regarding the site, please contact Truescreen's Help Desk at 888-276-8518, ext. 2006 or itsupport@truescreen.com.

Background Investigations are completed, on average, within 3 to 5 business days. Once completed, you will receive an email from Truescreen, studentedition@truescreen.com. Follow the link in the email to access Application Station: Student Edition to view the report. To access the site use the same username and password created at the time you submitted your background check. Application Station includes instructions for disputing information included in the background check should you feel anything is incorrect.

The initial background investigation consists of the search components listed below. All records are searched by primary name and all AKAs, a student's primary address, and all addresses lived within the past seven years.

- Social Security Number Validation and Verification
- County Criminal Records Search – all counties of residence lived in the past 7 years
- National Sexual Offender Registry Search
- Professional Licensing
- SanctionsBase Search (includes TN Abuse Registry)
- OIG/SAM

The cost of the Background Investigation is $40.25. Truescreen accepts credit cards and PayPal. Payment is collected within ApplicationStation: Student Edition.

STEP 2: What to do if you need a Drug Screen?

Below are step-by-step instructions for accessing Application Station: Student Edition to authorize and pay for a drug screen, as well as locate a specimen collection site. Drug screen collection facilities are listed on the final page of Application Station: Student Edition.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. Enter the Code: **WSCCNURS185-DS** in the Application Station Code field.
3. Click the "SIGN UP" button to create an account.
4. Follow the instructions on the Application Station web site.

Note – you can use the same username and password created for the background investigation. Please store the username and password created for Application Station in a secure location. This information is needed to enter Application Station in the future which includes obtaining a copy of your drug screen report.

If you encounter issues with the Application Station: Student Edition or have questions regarding the site, please contact Truescreen's Help Desk at 888-276-8518, ext. 2006 or itsupport@truescreen.com.

If none of the collection sites listed are convenient (within 30 minute drive), please contact Truescreen's Occupational Health Screening Department (i.e. TriTrack and Scheduling Hotline) for assistance with locating an alternate location; phone number 800-803-7859.

If the initial drug screen is reported as positive/non-negative, you will receive a call from Truescreen's Medical Review Officer (MRO). The MRO will obtain medical proof as to why you test positive. If you are taking any form of prescription medicine, it is wise to proactively proof from your physician to be provided to the MRO when contacted. This will speed up the process of reporting drug test results.

All drug screens conducted for Walters State Community College are 15-panel and tests for:

- Amphetamines
- Barbiturates
- Benzodiazepines
- Cocaine Metabolites
- Fentanyl
- Marijuana
- Meperidine
- Methadone
- Opiates
- Oxycodone
- Pentazocine
- Phencyclidine
- 6AM
- MDMA
- Buprenorphine

You will receive an email from Truescreen, studentedition@truescreen.com, once drug test results are available. Follow the link in the email to access Application Station: Student Edition to view the report.

The cost of the Drug Screen is $54.00. Truescreen accepts credit cards and PayPal. Payment is collected within ApplicationStation: Student Edition.

If the student receives a "REVIEW" (red X) or "FAIL" (solid red square) on either the background investigation or drug screen, the Nursing Program Director will communicate this information to the

Clinical Education Director at the respective clinical facility. The Clinical Education Director will then determine if the student can enter clinical rotations. The student is to schedule an appointment with the Clinical Education Director at the appropriate facility. During the scheduled appointment, the nursing student applicant will provide the original background check documentation to the Director of Clinical Education for verification and review. The Director of Clinical Education will review the conviction record and determine "clearing/not clearing" of the nursing student applicant based on approved criteria.

If permitted, an electronic copy of the background investigation can be forwarded to the Director of Clinical Education via Report Deliver Manager.

Report Delivery Manager

Report Delivery Manager (RDM) allows students to distribute an electronic copy of your background check and drug screen results to a third party for clinical rotations. RDM can be found in Application Station: Student Edition. Reports are available to students for 36 months. If reports are needed beyond 36 months, students must print a copy to be distributed as needed.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. To access the Report Delivery Manager, choose the "Returning user login" option on the right side of the home page and click "Log in."
3. Enter the username and password created at the time of submitting your background investigation and/or drug screen.
4. Click "View Report Delivery Manager" at the bottom of the ApplicationStation code for the program/application you need to deliver. This can be found after you completely log in and provide your ApplicationStation code.
5. A new screen will appear. To authorize a new third party to view a background check, click "Create a New Delivery."
6. Read the "Important Notice", type your name and click "Agree."
7. Supply the third party's contact information: Last Name, First Name and Organization. Report Access Keys are generated, including an ApplicationStation Code and Access PIN.

Truescreen recommends that the student contact the third party and provide the ApplicationStation website address, code and PIN to their contact verbally. This method provides the highest level of security. However, the student can also authorize that an e-mail containing this information be sent to the contact at the clinical facility. If you wish to have an email containing the Access Keys to be sent directly to the clinical facility, follow steps 8 and 9.

8. To authorize an e-mail, locate "Other Delivery Options, Option 2" and click "here to send an email."
9. Provide and confirm the recipient's e-mail address, and then select either Option 1 or Option 2, which determines what information is sent to the recipient via e-mail.

The system provides confirmation that an e-mail has been sent, along with the ApplicationStation Code and Access PIN for future reference.

WALTERS STATE COMMUNITY COLLEGE
HEALTH PROGRAMS

Medical History and Physical Examination Report of Applicant

APPLICANT IS TO COMPLETE THE FOLLOWING SECTIONS: ***BLUE OR BLACK INK ONLY***

Name:_____ Date of Birth:_____ Social Security No._____

Address:_____
Street City State Zip

Telephone: (Cell)_____ (Home)_____ (Work)_____

In case of emergency notify:
Name: _____

Address: _____

Telephone: _____ Relationship_____

	YES	**NO**	*DATE/EXPLANATION*
Allergies			
Asthma			
Cancer			
Diabetes			
Emphysema			
Eye Problems			
Hearing Problems			
Heart Problems			
High Blood Pressure			
Hepatitis			
Hernias (Rupture)			
Kidney Disease			
Rheumatoid Arthritis			
Seizures			
Thyroid Disease			
Tuberculosis			
Ulcers			
Additional Illnesses			
Surgeries			
Injuries (including back)			
Activity Restrictions			

Are you currently under treatment for any medical illness? If so, explain. If not, state "no" below.

_____

_____

List emotional or chemical dependency problems (past and or present) and treatment for such.

_____

_____

Signature of student:_____

Date:_____

MD/DO/NP/PA Report

Name_____ ***BLUE OR BLACK INK ONLY***

MMR	**1st Injection Date:** _____ **Mo/Day/Yr**	**2nd Injection Date:** _____ **Mo/Day/Yr**	**Flu Vaccine** (Annual*) *If student received vaccine elsewhere, attach documentation.* **Date:** _____ **Lot Exp:** _____ **Mo/Day/Yr** **Mo/Day/Yr**
If dates for MMR vaccines are unavailable, positive titers must be attached.			**Facility:**_____

Hepatitis B	**1st Injection Date:** _____ **Mo/Day/Yr**	**2nd Injection Date:** _____ **Mo/Day/Yr**	**3rd Injection Date:** _____ **Mo/Day/Yr**
If dates for Hepatitis B vaccines are unavailable, positive titer must be attached.			

Varicella (chicken pox)	**1st Injection Date:** _____ **Mo/Day/Yr**	**2nd Injection Date:** _____ **Mo/Day/Yr**	
If dates for Varicella vaccine are unavailable, positive titer must be attached.			

2-Step TB Skin Test (Annual*)	**1st Placement Date:** _____ **Mo/Day/Yr**	**Date Read/Reaction:** _____ _____ **Mo/Day/Yr** **+ / -**	**2nd Placement Date:** _____ **Mo/Day/Yr**	**Date Read/Reaction:** _____ _____ **Mo/Day/Yr** **+ / -**
Chest X-Ray Only required if TB positive.	**X-Ray Date:** _____ **Mo/Day/Yr**	**Result:** _____	**QuantiFERON TB GOLD Date:** _____ **Mo/Day/Yr**	**Result:** _____

Tdap **Date:** _____ **Mo/Day/Yr**	* Flu vaccine and TB skin test/TB GOLD must be repeated each year. Student must submit documentation to the Health Programs office. ** Tdap must have been received within preceding 10 years.

Medical Conditions Currently Being Treated: (List **all**. Include vaccine allergies if applicable.)

_____

_____

_____

Current Medications: (List **all**.)

_____

_____

_____

By signing this form, the health care provider (MD, DO, NP, PA) attests to having performed a physical on the student and affirms the student is capable of performing all duties of a health care provider without restriction.

_____ _____

HEALTH CARE PROVIDER SIGNATURE **HEALTH CARE FACILITY**

_____ _____

HEALTH CARE PROVIDER PRINTED NAME **FACILITY ADDRESS**

_____ _____

DATE **FACILITY PHONE**

Revised 3/2025

WALTERS STATE COMMUNITY COLLEGE

DIVISION OF HEALTH PROGRAMS

Flu Vaccination Form

NRSG 1620/1501/1340

Student Name (print):
_____

Date received: _____

Name of office/pharmacy/facility/clinic giving injection:

_____

Vaccination expiration date (date on vial): _____

Signature: _____

Student signature: _____

SUBMIT THIS FORM FOR 2025-2026 FLU SHOT

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
HEALTH INSURANCE CONSENT FORM

I,_____ am enrolled in Health Programs at Walters State Community College (WSCC).

Place initials beside each section.

I._____ Clinical Affiliates may require students carry health insurance. I must adhere to the requirements of the Clinical Affiliates I am assigned to as a Walters State Clinical Student.

II._____ I must be able to show proof of personal health insurance coverage should a Clinical Affiliate request to see it.

III._____ I am responsible for all costs incurred related to health insurance, health problems, or accidents that may occur while functioning in the role of a student.

IV._____ If I cannot meet the requirements of Clinical Affiliates to participate in the clinical portion of the course(s) in which I am currently enrolled, I will not be able to continue in the course(s).

V._____ I understand that should my insurance status change for any reason, I will notify the Health Programs Division immediately.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in WSCC Health Programs. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

This in no way negates or limits policies and procedures in program specific material.

_____ _____
Student's Signature Date

_____
Student's Name (Print)

WALTERS STATE COMMUNITY COLLEGE
DEPARTMENT OF NURSING
CONSENT FORM

I,_____ am enrolled in the Nursing program at Walters State Community College (WSCC). I acknowledge receipt and understanding of the Walters State Community College Nursing Program Student Handbook. My signature indicates that I have read and understood this consent and release, and I have signed it voluntarily in consideration of enrollment in the Nursing Program at Walters State Community college.

Place initials beside each section.

I._____ I have obtained a copy of the WSCC Nursing Program Student Handbook and catalog and agree to abide by the policies within.

II._____ I hereby give permission for the WSCC Department of Nursing to release information regarding my malpractice insurance policy and Basic Life Support course Completion to the clinical agency where I am assigned.

III._____ I hereby give permission for a copy of my current Health History and Physical or information from that document to be submitted to clinical facilities or their designees where I am assigned. I understand that this information will be released only by request of the clinical facility(s).

IV._____ I hereby give my permission for photocopying of my written work. I understand that this material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

V._____ I give my permission to WSCC to release personal identifiable information to the clinical facilities for the purpose of clinical education.

VI.____ I have read the Standard Precautions Procedure. I agree by my signature to abide by the contents within.

VII.____ I understand that WSCC strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

VIII.____ I hereby give my permission for the Walters State Community College Nursing Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the Nursing Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation and development, and publicity. These images will be retained by Walters State Community College.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in the WSCC Nursing Program. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

_____ _____
Student's Signature Date

_____
Student's Name (Print)

AGREEMENT FOR STUDENTS IN THE HEALTH PROGRAMS AT WSCC REGARDING STUDENT CONDUCT

The WSCC Health Program student agrees to conduct himself or herself in a professional, honorable, and ethical manner.

I. Professional Behaviors

A. Actively participates and accepts responsibility for learning
B. Effectively communicates
C. Demonstrates dependability
D. Demonstrates appropriate adaptability
E. Appropriately utilizes resources
F. Maintains acceptable level of personal appearance

II. Honorable and Ethical Behaviors

A. Demonstrates accountability for all actions
B. Demonstrates respect in all situations
C. Demonstrates ethical behavior in all situations

By accepting admission to the health programs as WSCC you are voluntarily agreeing to abide by the Student Conduct Agreement.

This in no way negates or limits policies and procedures in program specific material.

Student Signature _____

Date _____

WALTERS STATE COMMUNITY COLLEGE
NURSING PROGRAM
Student Confidentiality/Non-Disclosure Acknowledgement

Student_____

As a student in the Nursing Program, I understand that I will be working with medical records and confidential information for patients at various healthcare facilities.

I understand that healthcare facilities remind their employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue.

The healthcare facility/facilities that I may be assigned to have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at any healthcare facility that is an Affiliate of Walters State Community College, I may come into possession of confidential patient information.

Medical records are confidential, legal, personal documents. The contents of individual patient's medical records are to be kept strictly confidential. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at any time during or after my assignment with the Affiliate healthcare facility disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other that as necessary in the course of my assignment. When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care.

Nursing students must also treat as confidential all information relating to the personal, financial, and business affairs of the healthcare facility and its employees.

I pledge not to discuss the contents of any patient's medical record or any confidential information which comes to my knowledge except when such discussion is relative to the learning experience. I further agree to abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines in effect at the individual healthcare facility to which I am assigned. I understand that a violation of confidentiality in any of the above-described areas may be grounds for dismissal from the Nursing Program. I also understand that I may be in violation of the regulations of the Health Insurance Portability and Accountability Act of 1996 as effective April 14, 2003.

_____

Student's Signature **Date**

WALTERS STATE COMMUNITY COLLEGE
AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION AND ACKNOWLEDGEMENT

I, _____ hereby authorize Walters State Community College, ("Institution") including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of my background check and credential check(s) as these terms are generically used by background check agencies, hospitals, clinics and similar medical treatment facilities, to disclose the same to such facilities and the appropriate institutional administrators and faculty providing clinical instruction at such facilities, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic, or similar medical treatment facility may exclude me from clinical placement on the basis of a background check. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation. I release Institution and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check.

Any hospital, clinic or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic or similar medical treatment facility to which I am assigned, I will provide the results of my background check to be used for audit purposes only.

_____
Student Signature

_____
Print Name

_____
Date

Consent to Drug/Alcohol Testing
Statement of Acknowledgment and Understanding
Release of Liability

I, _____ am enrolled in the Allied Health and/or Nursing program at Walters State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Walters State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff; and property. Accordingly, I understand that prior to participation in the clinical experience, I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Walters State Community College.

If I am a licensed health profession, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test results are positive. Full reinstatement of my license would be required for unrestricted return to the Walters State Community College Allied Health and/or Nursing Program.

My signature below indicates that:
I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.
I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the Director of the Allied Health and/or Nursing Program, and others deemed to have a need to know.
I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Walters State Community College, and the Drug-Free Campus/Workplace Policy of Walters State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
I hereby release and agree to hold harmless Walters State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicated that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Allied Health and/or Nursing Program at Walters State Community College.

_____ _____

Student's Signature **Date**

WALTERS STATE COMMUNITY COLLEGE
DEPARTMENT OF NURSING
CLINICAL INFORMATION FORM

Please print legibly and return to instructor*

Course: NRSG 1620/1501/1340 **Semester:** FALL 2025

Campus: ☐ **Morristown** ☐ **Greeneville** ☐ **Sevierville**
(check one)

Name: _____
Last First Middle Preferred

Address: _____
Street

_____
City State Zip County

E-Mail: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Personal Health Insurance***:** _____ _____
(Must be able to provide documentation if facility requests.) Yes No

Special Needs:
(Class schedule, childcare issues, etc.)

Carpool Requests:
(Requests are not guaranteed.)

Previous Clinical Sites:

Employment Information:
(Place of employment, work hours, etc.)

_____ _____
Student Signature Date

****If the status of your health insurance coverage changes at any time,or if you need to update contact information please notify both your instructors and the Health Programs office.****