



Saint Francis Medical Center College of Nursing

A Tradition of Excellence in Nursing Education

Dear Incoming Student,

Welcome to Saint Francis Medical Center College of Nursing! Congratulations on beginning the first steps to becoming a professional nurse or to advance your nursing career. Best of luck to you on this journey!

It is important that you read through this entire packet very carefully. Details of the required health records are in the pages to follow. **There is a lot of information, and it is imperative that you pay attention to the details and follow the instructions.**

Several of the requirements may take an extended period of time to finish, so please begin working on health record submission as soon as possible.

Please Note: Any required titers (blood tests) should be drawn ASAP. Titers will show if additional immunizations are needed. More details are in the following pages of this packet.

Per College policy, **all students who do not have their health records in by the deadline will not be allowed to attend class or participate in clinical / practicum. Students who plan to stay in the dorm will not be allowed to move in if health records have not been completed.** In accordance with regulations of the Illinois Department of Public Health, OSF Saint Francis Medical Center, and student clinical sites, all students are required to present proof of immunity against vaccine preventable diseases. Completing the requirements protects your own health, your classmates, your patients, and others around you.

Proof of current CPR certification, health records, required forms, and any other required documentation must be submitted to: <https://www.viewpointscreening.com/>. Please see the following pages for information regarding the creation of a Viewpoint account, the associated costs, and other important information regarding the submission of documentation. All required documents must be in Viewpoint under the appropriate requirement to make that requirement "complete". **It is your responsibility to double-check your account and ensure that everything has been completed and accepted. If you have any questions, viewpoint has an online chat feature that is available.**

Thank you and welcome to Saint Francis Medical Center College of Nursing!

VIEWPOINT INSTRUCTIONS FOR SFMC COLLEGE OF NURSING STUDENTS

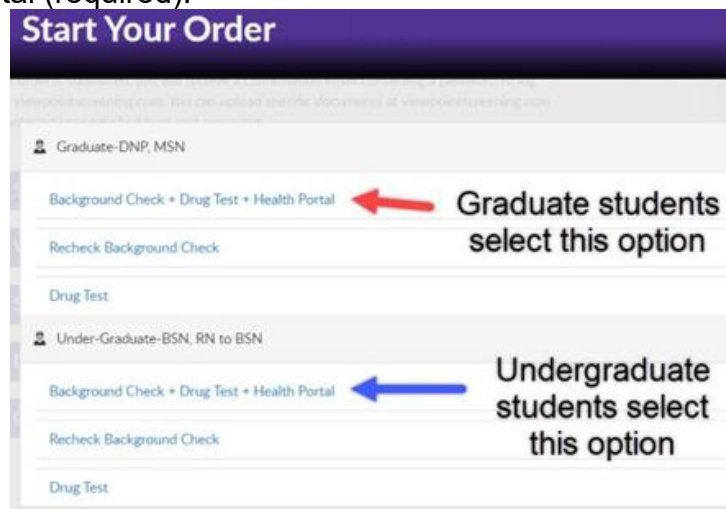
About Viewpoint

Viewpoint is a secure platform that allows you to order your background check, drug screen, and health records / immunization tracker online. Once you have placed your order, you may use your login to access additional features of Viewpoint, including document storage, portfolio builders, and reference tools. Viewpoint also allows you to upload any additional documents required by the College.

It is your responsibility to double-check your account to ensure that the documentation submitted was accepted. If a document is rejected, Viewpoint will tell you why. Please read that information and try to resolve the issue. Viewpoint also has an online chat feature that is available.

Place Your Order

Go to: <https://www.viewpointscreening.com/osfhealthcare> and select: Background Check + Drug Test + Health Portal (required):



Required Personal Information

In addition to entering your full name and date of birth, you will be asked for your Social Security Number, current address, phone number, and email address. Please keep your email address updated in Viewpoint. Important information and reminders (e.g., for CPR renewal, immunization due dates, etc.) will be sent to the email address you provide. Do not ignore messages from Viewpoint as no other reminders will be sent to you.

Payment Information

At the end of the online order process, you will be prompted to enter your Visa or MasterCard information.

Go to: <https://www.viewpointscreening.com/osfhealthcare>

VIEWPOINT VP SCREENING



SAINT FRANCIS
MEDICAL CENTER
COLLEGE OF NURSING



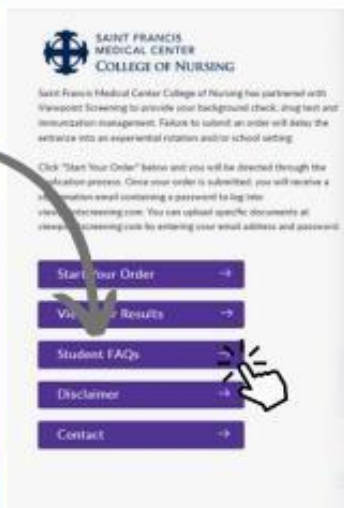
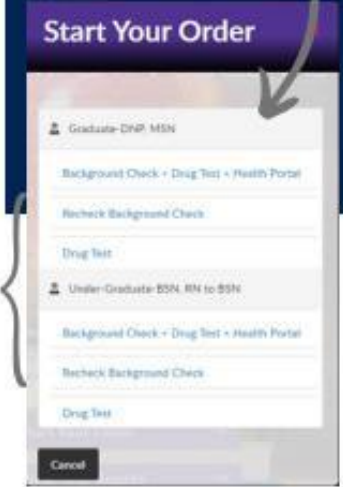
How to Order Your:

- Background Check
- Drug Test
- Health Portal

1 STEP 1: GO TO the School's Landing Page on Viewpoint Screening's Website:
<https://www.viewpointscreening.com/osfhealthcare>

2 Click on 'Start Your Order'

3 Choose your PROGRAM.
Then Click on the link to choose Background Check + Drug Test + Health Portal.



4 Review Package
Once you click on the link, you will be taken to a package summary screen. Once you review your package and the terms of use policy, click the button to acknowledge and hit NEXT.

5 Complete the APPLICANT INFORMATION and address sections as prompted.

Applicant Information

Do not place an order on someone's behalf. This form must be filled out by the individual who requires Viewpoint Screening services.

First Name:

Last Name:

Middle Name:

Alias/Maiden Name 1:
Please Note: If you DO NOT have an alias name, leave this field blank. Only provide if you have used an alias within the last 7 years.

Alias/Maiden Name 2:
Please Note: If you DO NOT have an alias name, leave this field blank. Only provide if you have used an alias within the last 7 years.

Alias/Maiden Name 3:
Please Note: If you DO NOT have an alias name, leave this field blank. Only provide if you have used an alias within the last 7 years.

Social Security Number:
Please Note: If you have not been issued a valid U.S. SSN then enter all zeros (000-00-0000) instead.

Date of Birth: / / (mm/dd/yyyy)

Gender: Male Female

Phone Number: (111-111-1111)

E-Mail Address*: **IMPORTANT** your email address will be your user name to

Current Residential Address

Address:

City:

State or U.S. Territory*:

For an international address, select "International" and select the foreign Country name below.

Country*: United States

Zip Code: [ZIP Code Lookup Tool](#)
Please Note: If you have an international address that does not require a Zip Code, please fill in "00000".

Please make sure you have provided correct information. Changes cannot be made once you have placed your order.

6 Complete payment section.

Payment Information

First Name:

Last Name:

Credit Card Number:

Exp. Date: (MM/20YY)

CVV2:

Credit Card Type: Select Card Type

Contact Name (if business):

Email:

Phone Number:

Address:

City:

State:

Postal Code:

IMPORTANT: Please note that if you enter an address other than the one on file with the credit card's issuing bank, or an incorrect CVV code, Viewpoint Screening will deny your transaction for security purposes. Additionally, denied transactions may cause the funds to be held by your bank for up to 5 business days before being released back to the card.

Viewpoint LLC will appear on your credit card statement.

A Parent or Guardian's credit card will be accepted.



WARNING: Your credit card will be charged when you click "Next." This fee is non-refundable.

Do not click more than once or you may be charged multiple times.

7 Log In to Your Account

Once your order is complete, you should be taken to a screen to like this to the right.

Your username will be the email you used to set up your account.

Change password here, and it will log you in to the Viewpoint System.

Thank you, your order has been submitted. Please be aware that this order also will require a background check on a flag day.

You can now access your Health Portal to upload required documents.

You will be automatically logged into your account once you create/change your password.

Please RESET THE PASSWORD to your account associated with [@viewpoinths.com](#).

Passwords must contain three or more numbers, one or more special characters, and must be at least 10 characters long.

Re-enter Web password: Toggle Password

Confirm Web password:

I have provided a strong password that will be remembered

NEXT ➔

NEXT STEPS:

- HEALTH PORTAL:** Follow instructions on following pages to view your Health Portal requirements (to upload documents).
- DRUG TEST:** You will receive an email with instructions and registration info 1-2 days after ordering.

TO LOG IN

Go to
www.viewpointscreening.com
Right Hand Corner: **LOG IN**

Username
Password
Clear Password
Log In
Registration email address?

Click here if you forget your username or password to request to have it emailed to you.

View your HEALTH PORTAL REQUIREMENTS

Now you are logged into your Viewpoint Screening Account. This is your Dashboard. Click "Health Portal" to VIEW requirements.

Dashboard

- Results
- Drug Testing
- Health Portal
- Health Portal Messages
- eLearning
- Fingerprinting

HOW TO SEE REQUIREMENTS & UPLOAD DOCUMENTS

Health Portal

Acceptable Files

This section has FAQ's and helpful information - please READ IT - it will help!

CHES Form Requirement Description

OSHA / Bloodborne Pathogens Training Requirement Description

To VIEW YOUR GUIDELINES (what to do) for a particular requirement, click on that item's "Requirement Description."

CHES Form Requirement Description

Due Date: 08/31/2022

Submit a copy of the signed CHES Form

This is 'Form C' from the Workforce Development Board website: <https://medbtccw.org/Clinical>

[Click here for the CHES form](#)

Select File Close

Guideline Description Box

- From here, you can:
- View the guidelines for what to upload
 - See important instructions
 - View & download school forms
 - Upload a file to correspond with this requirement

Due Date: 08/31/2022 Upload CHES Form Document

Due Date: 08/31/2022 Upload OSHA / Bloodborne Pathogens Training Document

SAMPLE HEALTH PORTAL

TIPS

- READ the full guideline to make sure you provide the right documentation.
- Viewpoint Screening does not create your requirements. The school communicates requirements to us. Our role is to verify documentation.
- Make sure your name is visible on the document (before and AFTER upload).

HOW TO UPLOAD A DOCUMENT

When you have the correct document available, you are ready to upload it to your Health Portal.

CHES Form
Requirement Description

Due Date: 04/01/2022

Upload CHES Form Document

Submit a copy of the signed CHES Form
This is 'Form C' from the Workforce Development Board website: <https://wdbbcw.org/clinical-s>
[Click here for the CHES form](#)

Select File Close

CLICK either of these places to upload a document

Once the document has been successfully uploaded, a new button will appear in the Row of the item with the DATE UPLOADED.

			date upload column	document status column	action date column
Hepatitis B Requirement Description	Click to view the document(s) you have uploaded	Upload New Hepatitis B Document	Document Uploaded On 04/07/22	Document Not Approved 04/08/22	Next Action Date
MMR Requirement Description	Click to view the document(s) you have uploaded	Upload New MMR Document	Document Uploaded On 02/17/22	Document Approved 02/17/22	Next Action Date 01/01/2030

Is my document approved or not approved? ?

Documents are reviewed in 24 hours, or in 1 business day if submitted on weekends. Once reviewed, every document is either APPROVED (and marked green), or NOT APPROVED (and marked red), with a date stamp of review.

Upload New Hepatitis B Document	Document Uploaded On 04/07/22	Document Not Approved 04/08/22	Next Action Date
Upload New MMR Document	Document Uploaded On 02/17/22	Document Approved 02/17/22	Next Action Date 01/01/2030

How can I see what I uploaded?

Click to view the document(s) you have uploaded

Always CHECK what you uploaded.

- ✓ Is it the right doc?
- ✓ Is my name visible?

If a document is NOT APPROVED, you will receive an email notifying you with the reason for the rejection. This information can also be located at the bottom of your Health Portal listings under "HEALTH PORTAL MESSAGES."

[Hepatitis B Titer](#)
Requirement Description

Click to view the document(s) you have uploaded

Upload New Hepatitis B Titer Document

Document Uploaded On 04/07/22

Document Not Approved 04/08/22

Next Action Date

Health Portal Messages

04/20/2022	blah blahblah
04/08/2022	Hepatitis B - Please make sure to include your name on your document.
07/22/2021	You did not provide the correct document.
12/01/2020	CPR Certification - You have provided a non-BLS (Basic Life Support) certificate. Please submit a BLS certificate in order to gain approval.



You will receive a general reminder email once weekly until you have reached full compliance for all of your documents.

Support



Email us at:
studentsupport@viewpointscreening.com



Instant Chat - bottom right hand corner at ViewpointScreening.com
Monday - Friday 9 am - 5pm EST.

Required CPR Certification

SFMC College of Nursing will only accept actual American Heart Association (AHA) or courses at the healthcare provider level are acceptable: **American Heart Association (AHA), BLS (Basic Life Support) Provider**

It is important to note that **it is the student's responsibility** to keep CPR certification up-to-date and on file in Viewpoint while attending SFMC College of Nursing.

Failure to meet this requirement will result in the student not being allowed to participate in class, clinical, or practicum along with loss of access to the learning management system. A grade of zero (0) will be entered for any classroom, clinical, or practicum activities until the student is in compliance with the requirement. CPR renewal should be scheduled well in advance of expiration to allow ample time for completion before the certification expires.

OSF Mission Partners only: The online Heart Code certificate and Hands-On Completion certificate from OSF Corporate University will be accepted as proof of certification. Both certificates must be uploaded together at the same time to complete the requirement.

Please note: The College of Nursing does not have access to OSF Corporate University documents or immunization records from Occupational Health. It is the student's responsibility to obtain those records and upload them to Viewpoint.

Required Health Forms

Requirement	Undergrad BSN Students	RN-BSN Students	Graduate Students
RN License	Select "No" under this requirement	Select "Yes" & submit copy of current RN license	Select "Yes" & submit copy of current RN license
HIPAA Form	Complete form included in health packet & upload	Complete form included in health packet & upload	Complete form included in health packet & upload
Latex Sensitivity Health Form	Complete form included in health packet & upload	Complete form included in health packet & upload	Complete form included in health packet & upload
Medical History Form	Complete form included in health packet & upload	Complete form included in health packet & upload	Complete form included in health packet & upload
Core Performance Standards & Criteria of Admission & Progression	Complete form included in health packet & upload	Complete form included in health packet & upload	Complete form included in health packet & upload
Physician/Advanced Practice Provider Confirmation of Records Form	Must be completed by Physician or Advanced Practice Provider & uploaded	Must be completed by Physician or Advanced Practice Provider & uploaded	Must be completed by Physician or Advanced Practice Provider & uploaded
Consent to External Background Check and Disclosure of Information	Complete form included in health packet & upload	Complete form included in health packet & upload	Complete form included in health packet & upload

Required Testing/Screenings

11-Panel Urine Drug Screen

- All students must register for the urine drug screen through Viewpoint.
 - **Screening must take place at a facility designated by Viewpoint – no exceptions!** A drug screen completed at any other facility will be rejected, and the student will be required to re-test at an authorized facility. The student is responsible for any additional costs incurred.
 - **Fall 2026:** Drug screen must be completed **July 7 - 17, 2026.**
-

Tuberculosis Screening

A 2-step skin test or QFT blood draw with negative results within the past year is required.

2-Step skin test done 1-3 weeks apart

- Step 1 of the test is administered. (Step 1 must be read 48-72 hours after administration.)
- Step 2 is administered no less than 7 days and no more than 21 days after Step 1. (Step 2 must be read 48-72 hours after administration.)
- **Upload results of skin test (after both steps have been completed).**

OR

- **Quantiferon Gold TB (QFT) Lab Report** with a negative result.
- A clear chest x-ray is required for any positive TB test.

Please note that a 1-step TB skin test (or yearly 1-step TB skin tests) is not acceptable under any circumstances.

Measles, Mumps & Rubella (MMR)

- **Proof of two (2) MMR vaccines**

If proof of two MMR vaccines cannot be provided, then titers (blood draw) are required:

- Measles (Rubella)
- Mumps
- Rubella

A quantitative lab report with the result, reference range, and interpretation must be uploaded to Viewpoint.

If any of the MMR titers are negative, the student is required to receive a *MMR booster vaccine*. Proof of immunization must then be uploaded to Viewpoint.

Varicella (Chicken Pox)

- **Proof of two (2) doses of the Varicella vaccine**

If proof of both Varicella vaccines cannot be provided, a positive titer is required.

- A quantitative lab report with the result, reference range, and interpretation must be uploaded to Viewpoint if a titer is drawn.
- If the titer is negative, the **2-vaccine Varicella series done 4-8 weeks apart** is required.

Proof of immunization must be uploaded to Viewpoint as each vaccine is received. Do not wait until the series is finished to upload documentation.

Hepatitis B

- If the student has received the 3-vaccine series at any time previously, upload documentation of the original series.
- A positive **Hepatitis B Surface Antibody titer is required** to detect immunity.
- A quantitative lab report with result, reference range, and interpretation must be uploaded to Viewpoint.
- Please note that the Hepatitis B Antigen titer will not be accepted, and the student is responsible for obtaining a Hepatitis B Surface Antibody titer.
- The CDC recommends, and the College requires, that healthcare personnel with written documentation of having received a properly spaced series of Hepatitis B vaccines in the past (such as in infancy or adolescence) but who now test negative for anti-HBs should receive the **Hepatitis B series of three vaccines** (or two vaccines followed by another titer).
- If the student chooses the two vaccines/2nd titer pathway and the 2nd titer is also negative, the student is required to receive the 3rd Hepatitis B vaccine.
- Proof of immunization must be uploaded to Viewpoint as each vaccine is received. Do not wait until the series is finished to upload documentation.
- “High Risk” individuals should not receive the Hepatitis B vaccine series. Individuals in this category include people with:
 - a history of Hepatitis B infection or presence of a serious concurrent infection,
 - presence of a serious concurrent infection,
 - or a documented allergy to yeast or formaldehyde.
- “High Risk” individuals should contact the Administrative Secretary for a declination waiver which must be completed and uploaded to Viewpoint.
- Per the CDC, many years of experience with Hepatitis B vaccines indicate no apparent risk for adverse events to a developing fetus. Current Hepatitis B vaccines contain noninfectious Hepatitis B surface antigen (HBsAg) and should pose no risk to the fetus. **However, please double-check with your OB provider prior to receiving any vaccine(s) during pregnancy.**

Please Note: A titer is a blood test that will show if a student has immunity. An equivocal or

negative titer means that the student will need additional immunizations.

If the **Hepatitis B 3-vaccine series** is needed for any reason, the series is normally done over a 6-month time frame. Although the series does **not** have to be completed prior to, the first vaccine must be received prior to the beginning of classes (unless an alternate plan has been arranged). Please upload each vaccine as you receive it – do not wait until the series is completed. This also applies to the **Varicella 2-vaccine series** which is done 4-8 weeks apart.

The Hepatitis B 3-vaccine schedule is as follows:

- **Vaccine #1 is received.**
 - **Vaccine #2 is received four weeks after vaccine #1.**
 - **Vaccine #3 is received five months after vaccine #2.**
 - If a student chooses to have two vaccines and then a 2nd titer, the titer is drawn four weeks after vaccine #2. If the 2nd titer is negative, the student is required to receive the 3rd vaccine.
-

Meningococcal Conjugate Vaccine (MCV)

- Any incoming student under the age of 22 must provide documentation showing receipt of one (1) dose of the MCV on or after their 16th birthday.
 - Students under the age of 22 must select “Yes” and submit proof of the MCV.
 - This vaccine is also strongly recommended for all incoming dorm students who are younger than 22 years of age.
 - If you are 22 years of age or older and will not be submitting an MCV, please select “No” for this requirement.
-

Tetanus/Diphtheria/Pertussis (TDaP)

- All students in Illinois must provide documentation of a minimum of three (3) doses (DPT/Td) with at least one (1) dose of TDaP within the past 10 years.
 - TDaP must be renewed every 10 years. Re-vaccination of TDaP (or Td) is required every ten (10) years.
 - If a student is unable to receive the vaccine due to allergy, medical condition, etc., a written note must be provided by the student’s healthcare provider.
-

Influenza

- **All healthcare workers (including students) in the state of Illinois are required to receive a yearly Influenza vaccine.**
- Incoming students for the **spring semester** are required to provide proof of vaccination by the health record deadline.


- **Incoming students for the fall semester must wait until September / October** to receive the Influenza vaccine and upload proof of vaccination for the current flu season.
- The **only** exemptions allowed in the state of Illinois are for 1) a sincere, deeply held religious objection or 2) a valid medical reason. **General philosophical or personal beliefs are not considered to be a valid reason.**
- **If a student did not receive a flu shot due to an approved medical or religious exemption, that student will still be required to wear a mask, covering both nares and mouth, at all times when in the College of Nursing building, OSF HealthCare Saint Francis Medical Center building(s), White School / Labs, or any clinical site when flu precautions are in place.**
- Failure to complete the Influenza requirement will result in the student not being allowed to participate in class, clinical, or practicum along with temporary loss of access to the learning management system (Canvas). A grade of zero (0) will be entered for any classroom, clinical, or practicum activities until the student 1) has received a flu shot, 2) has an approved medical exemption, or 3) has an approved religious exemption on file in Viewpoint.

Deadlines for Health Records, Criminal Background Check & 11 Panel Urine Drug Screen

Requirements for Fall 2026	Deadline
Upload Immunization / Health Records and complete Criminal Background Check on: www.viewpointscreening.com/osfhealthcare	Before July 24, 2026
Complete 11-Panel Urine Drug Screen and transfer results from <i>My Documents</i> → <i>To Do Lists</i> under the <i>Drug Test</i> requirement on www.viewpointscreening.com/osfhealthcare	Between July 7-17, 2026

HIPAA Form


Saint Francis Medical Center College of Nursing
511 N. E. Greenleaf Street, Peoria, IL 61603


Printed Student Name

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Federal law requires Saint Francis Medical Center College of Nursing and its related health care providers/caregivers to maintain the privacy of individually identifiable health information and to provide you with notice of their legal duties and privacy practices with respect to such information. Saint Francis Medical Center College of Nursing and its related health care providers must abide by the terms and conditions of this law.

Saint Francis Medical Center College of Nursing may use or disclose your individually identifiable health information for treatment and health care operations. These categories are involved in delivering the health care services that you seek and the quality and safety of those services. These activities may include release of your health records to the College physician or authorized personnel. I understand the above HIPAA guidelines and approve.


Student Signature

Date

Latex Sensitivity Health History
Saint Francis Medical Center College of Nursing
511 N. E. Greenleaf Street, Peoria, IL 61603



Printed Student Name

- | | |
|---|----------|
| 1. Do you have a latex allergy? | Yes / No |
| 2. Do you have any swelling/itching of your lips after blowing up balloons? | Yes / No |
| 3. Have you experienced any swelling/itching after dental, vaginal or rectal exams or using condoms? | Yes / No |
| 4. Do you have any history of eczema or dermatitis of the hands? | Yes / No |
| 5. Do you have any other skin problems? | Yes / No |
| 6. Do you have any food allergies? | Yes / No |
| 7. Do you have any other allergies? | Yes / No |
| 8. Do you have a history of unexplained nasal congestion, itchy, watery eyes or chest congestion? | Yes / No |
| 9. Have you had multiple surgical procedures as an infant? | Yes / No |
| 10. Have you ever experienced any unexplained acute allergic reaction during or after a surgical procedure? | Yes / No |

If you answered "Yes" to any of the questions above, please explain below:



Student Signature

Date

Medical History Form

All medical information is strictly confidential. Please answer the questions below.

- | | |
|---|----------|
| 1. Allergic reactions to any medicines? Please specify medicine and type of reaction. | Yes / No |
| 2. Serious reactions to insect bites or food? | Yes / No |
| 3. Infectious Mononucleosis? | Yes / No |
| 4. Chicken Pox? | Yes / No |
| 5. Hepatitis? What type? | Yes / No |
| 6. High Blood Pressure? | Yes / No |
| 7. Heart Murmur? Other cardiac disorders? | Yes / No |
| 8. Diabetes, thyroid or other endocrine disorders? | Yes / No |
| 9. Asthma? Bronchitis? | Yes / No |
| 10. Colitis, abdominal pain, gastric disorders? | Yes / No |
| 11. Shingles? | Yes / No |
| 12. Kidney Stone? Kidney disorders? | Yes / No |
| 13. Anemia? Blood disorders? | Yes / No |
| 14. Back pain, disorders of the bone, muscle or joint? | Yes / No |
| 15. Frequent or severe headaches or migraines? | Yes / No |
| 16. Seizure disorder, convulsions, past head injury or concussions? | Yes / No |
| 17. Disabling loss of vision? | Yes / No |
| 18. Do you take medication (prescribed and/or over the counter) on a regular basis? If so, please list below. | Yes / No |
| 19. Have you had any serious dietary problems? | Yes / No |
| 20. Any operations, hospitalizations or serious injuries? Please specify. | Yes / No |

If you answered "Yes" to any of the questions above, please explain below:

Printed Emergency Contact Phone

Student Signature

Date

Core Performance Standards & Criteria of Admission & Progression

In compliance with the American Disability Act, Saint Francis Medical Center College of Nursing does not discriminate on the basis of disability in the administration of its educational policies, admission policies, student aid and other college administered programs nor in the employment of its faculty and staff. The skills listed below are essential requirements for this program. We invite any potential student to meet with the Dean to discuss any issues associated with meeting or not meeting these requirements.

Issue	Standard	Some Examples of Necessary Activities (not all inclusive)
Critical Thinking	Patient Client needs/Problem Solving/Critical Thinking ability sufficient for clinical judgment. Use verbal, nonverbal cues to identify patient/client needs/problems.	Identify cause-effect relationships in clinical situations. Develop nursing care plans. Make judgments regarding appropriate interventions based on signs and symptoms.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families and groups from a variety of social, emotional, economic, religious, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues and other health care providers.
Communication	Communication proficiency at a competent level in English, both verbal and written, to include reading, writing, spelling, speaking and listening.	Explain treatment procedures, initiate health teaching, document and interpret nursing actions and patient/client responses. Document clearly, correctly, and without spelling errors. Read and write at college levels.
Mobility	Physical abilities sufficient to provide safe and effective nursing care.	Work in a standing position with frequent walking most of an eight-hour day; bend & stoop, push & pull objects such as a wheelchair, cart, gurney or equipment; lift & transfer clients from a stooped to an upright position.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective nursing care.	Calibrate and use equipment; administer medications; position patients/clients.
Hearing	Auditory ability sufficient to monitor and assess health needs, to communicate with individuals, families, groups, communities and health care professionals, and to provide therapeutic interventions accurately.	Hear & respond to verbal communication and requests: respond to emergency signals, auscultatory sounds, percussion and auscultation, and hear cries for help.
Visual	Visual ability sufficient for observation, assessment and provision of nursing care.	Observe and respond to patients/clients and provide therapeutic interventions accurately; closely examine images or other forms of output from diagnostic equipment or patient body fluids; visually discriminate medication and syringe labels; determine variations in skin color of client.
Tactile	Tactile ability sufficient for observation, assessment and provision of nursing care.	Perform palpation and other functions of physical examination or those related to therapeutic intervention, e.g., insertion of a catheter.
Other	Mental alertness sufficient to provide safe, effective nursing care.	Observe and respond to patient/clients and provide therapeutic interventions accurately and safely. Able to concentrate and remain on task to completion.

Adapted from the Southern Council on Collegiate Education in Nursing guidelines with minor additions or changes.

**There may be more stringent requirements for clinical agencies that may preclude the student's progression in the nursing program. (revised 2/2005)

I have read the above Core Performance Standards & Criteria of Admission and Progression and hereby represent that I can effectively and safely perform the competencies listed.

Student Signature

Date

I attest that the information stated in this Health Record Packet is correct. Any false information may result in cancellation in my admission to the College.

Student Signature

Date

Physician/Advanced Practice Provider Confirmation of Records Form

Printed Student Name

Tetanus/Diphtheria & Pertussis (TDaP): _____

- TDaP must be current within the past (10) years.
- Students in Illinois must provide a record of a minimum of (3) doses (DPT/Td/TDaP).

Measles/Mumps/Rubella (MMR):

- If you were born after 1/1/1968, you will need proof of 2 MMR immunizations with doses being at least 30 days apart or positive titers:
MMR #1: _____ **MMR #2:** _____ **Booster (if applicable):** _____
- If you do **not** have documentation of the immunizations, titers of immunity are required:
Measles (Rubella): _____ Mumps: _____ Rubella: _____

Hepatitis B:

- Due to direct patient contact, the Hepatitis B series with a positive titer result is required:
Original Series Dates: #1: _____ #2: _____ #3: _____
- **Hepatitis B Surface Antibody titer:** _____
If negative, a repeat 3-vaccine Hepatitis B series (or 2-vaccine series followed by a positive titer) is required.

Varicella (Chicken Pox):

Due to direct patient contact in the areas of high risk health conditions, the Varicella titer is required. If negative, the 2-vaccine series will be administered 4 to 8 weeks apart.

- Varicella titer date: Vaccine #1: _____ Vaccine #2: _____

TB Testing: 2 Step TB skin test (completed within the past 12 months done 1-3 weeks apart)

Step 1 TB Date: _____	Step 2 TB Date: _____
Site: _____	Site: _____
Signature: _____	Signature: _____
Induration: _____	Induration: _____
Signature: _____	Signature: _____

(Please upload **one document with both steps** for the 2-step TB skin test)

OR

QFT (Quantiferon Gold TB) blood test results: _____

MCV (Meningococcal Conjugate) after 16th birthday (if less than 22y.o.) Date: _____

*****Students must upload the official lab report with reference range / result / interpretation for any titer results.**

Printed Provider Name

Provider Address (city, state, zip)

Phone

Provider Signature

Date



Saint Francis Medical Center College of Nursing

A Tradition of Excellence in Nursing Education

I am aware that I need to seek **Emergency Medical Attention** if I have:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion
- Inability to wake or stay awake
- Bluish lips or face

I acknowledge that I will be sent home if I am not feeling well or look ill while at the College or clinical site. If I am not able to leave immediately for home, I acknowledge that I will be placed in isolation as a prevention of transmission strategy until departure occurs.

If I have had a close exposure to someone with confirmed COVID-19, I know that I need to test and watch for symptoms of COVID-19.

If I have been sick with COVID-19 symptoms or tested positive for COVID-19, I realize I need to stay home until I have been fever-free for at least 24 hours without the use of a fever reducing product (i.e. acetaminophen or ibuprofen) **and** respiratory symptoms have improved (e.g., cough, shortness of breath) **and** it has been 10 days since symptoms first appeared.

I will notify the appropriate dean, and instructor(s) of my illness or exposure and communicate at least weekly with an update on my condition. I understand the College will work with me regarding work opportunities, if feasible, while I am away.

Printed Student Name

Student Signature

Date

Complete this page and upload both pages to Viewpoint.

Consent to External Background Check and Disclosure of Information

Saint Francis Medical Center College of Nursing

511 N. E. Greenleaf Street, Peoria, IL 61603

I hereby authorize **Saint Francis Medical Center College of Nursing** (hereinafter referred to as “College of Nursing”) or any qualified agent, or clinical facility, where I may receive clinical education (“Clinical Facilities”) to receive the following in connection with my clinical educational experience: immunization record and criminal background information including copies of my past and present law enforcement records to include both misdemeanor and felony convictions. This criminal background investigation is conducted for the purpose of assisting the **College of Nursing** and Clinical Facilities in evaluating my suitability for a clinical experience. The release of information pertaining to this criminal background investigation to those persons necessary to determine my suitability to participate in the clinical educational experience is expressly authorized.

I understand that information contained in the criminal background report may result in my being denied a clinical experience and may result in dismissal from the **College of Nursing**. If negative information is contained in my report, I understand that I will be notified by the College of Nursing and I have the right to contest the accuracy of the report and subsequently provide documentation the report is in error.

I hereby give the **College of Nursing** permission to obtain and release criminal background information to facilities to which I may be assigned for clinical experience prior to beginning the assignment. I hereby release and hold harmless the **College of Nursing**, OSF Healthcare System, its trustees, the College Board, OSF employees and agents, and Clinical Facilities (all hereinafter referred to as “OSF”) from liability or damage in providing such criminal background information or acting on such information. I hereby agree that a copy of this authorization may be accepted with the same authority as an original.

I hereby further release the OSF from any and all claims including but not limited to, claims of defamation, invasion of privacy, negligence or any other damages resulting from or pertaining to the collection of this information.

I also agree that I must immediately report any future criminal convictions to the Dean Undergraduate or Graduate Program at the **College of Nursing**.

My signature below certifies: a) agreement and approval of the above statements; b) that all information given is true and reliable; and c) that I am responsible for all fees associated with this process. Any false information given may result in dismissal from the **College of Nursing**.

Printed Name

Student Signature

Date

Health Records Checklist

DUE: July 7-17, 2026

- Urine Drug Screen (must be done at a Viewpoint designated lab)

DUE: July 24, 2026

- Criminal Background Check
- CPR (Healthcare provider level – AHA or RQI for Mission Partners)
- TB Screening (2-step skin test or QFT blood draw)
- MMR (proof of 2 vaccines or positive titers)
- Varicella (**titer is required**)
- Hepatitis B (**Hepatitis B Surface Antibody titer is required**)
- MCV (**required for all students younger than 22-years-old**)
- Tdap (within the past 10 years)
- HIPAA Form
- Latex Sensitivity Health Form
- Medical History Form
- Core Performance Standards & Criteria of Admission & Progression
- Physician/Advanced Practice Provider Confirmation of Records Form
- Consent to External Background Check and Disclosure of Information
- RN license (required for RN to BSN & Graduate students)*
*Undergraduate BSN students should mark “No”

DUE: October 31, 2026

- Influenza vaccine proof uploaded to Viewpoint.