CUA

THE CATHOLIC UNIVERSITY OF AMERICA
School of Nursing
Washington, DC 20064
202-319-5400
FAX 202-319-6485

CERTIFICATION OF CLINICAL READINESS

Certification by Health Care Provider

I, _____ , hereby certify that I have completed a physical
(Name of physician, certified nurse practitioner, certified physician's assistant)

examination on _____ and that in my medical opinion there are:
(Name of student/patient)

____ No current conditions which would disqualify the student from participating in the nursing clinical rotation at the present time.

____ Limitations which include:_____
(examples: Medical conditions, Mental conditions, or Chemical Dependency; other sheets may be used to explain limitations)

Please check one of the following:

_____ I can recommend
_____ I cannot recommend

Provider Signature: _____Date: _____

Provider Printed Name: _____

Provider Address: _____Telephone: _____

_____

Certification by Student

I have read the above and hereby certify that it is complete and accurate and that I have fully disclosed any conditions that might interfere with the Safe Nursing Practice requirements at The Catholic University of America, School of Nursing

Printed Name: _____ Signature: _____

Date: _____

MUST SUBMITTED ANNUALLY ***DO NOT SUBMIT TO SON, SUBMIT TO CERTIFIEDBACKGROUND.COM
June 2012