Allied Health Student Checklist
Please Print

Name of Program Official Completing Form: P. Michael Peterson
Position: Director Health Behavior Science Internship, Dept Chair Behavioral Health & Nutrition
E-mail: cbonnett@udel.edu Phone #: 302.831.8729

Student Name: ________________________________________________________________
Requested Rotation Start Date: ________________________________

We need to have a current certificate of liability coverage from your school on file. Students will not be cleared without a current COI that documents coverage limits as outlined in the clinical affiliate agreement.

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Verification that student is in good standing in program
Criminal Background Check completed with no findings*
Negative Drug Screen Results received
Evidence of current (annual) TST skin test (PPD)
Chest x-ray and annual symptom review if TST is positive

Evidence of immunization for the following:
- Tetanus, Measles, Mumps, Rubella, Varicella (if unknown H/O Chicken pox)
- Hepatitis B
- Seasonal Flu (if rotating from November – March)

An Adult Abuse Registry will be completed by our office. Any positive results will be referred back to the program official.

A Child Protection Registry Request form has been given to the student to complete and fax to DSCYF. Any positive results will be referred back to the program official.

*The student applicant with positive findings on their criminal background check must mail or fax their results to the Allied Health offices for review. Upon completion of the review, it will be determined if the student can participate in a clinical experience at any Christiana Care facility.

Mail positive findings to: Allied Health Program Office, Riverside Medical Arts Complex, Suite 101
700 W. Lea Boulevard, Wilmington, DE 19802
OR
Fax to: 302-762-3704

I hereby certify that the student listed above is cleared to participate in a clinical experience according to Christiana Care standards and the guidelines set forth in the Visiting Student Responsibilities for Rotations at Christiana Care.

Signature: ___________________________ Date: ________________
(School Program Official) Revised 02/2014