



FLORIDA ATLANTIC UNIVERSITY
CHRISTINE E. LYNN COLLEGE OF NURSING
777 GLADES ROAD
BOCA RATON, FL 33431
PHONE (561-297-2872)
FAX (561-297-0293)
Visit us at <http://nursing.fau.edu/>

BACKGROUND CHECKS

State legislation requires a full background check for all individuals in process of admission to the Christine E. Lynn College of Nursing. Partnering agencies where students receive nursing practice experiences also require background checks, as well as verification of employment, and social security verification aimed at protecting the public.

Therefore, as a condition of admission each student **MUST COMPLETE** the background check process before beginning any coursework.

PROCESS

1. Make sure the Florida Atlantic University and the Christine E. Lynn College of Nursing application for admission is completed and you are admitted conditionally to one of our programs **BEFORE** beginning with the background check.
2. Complete the **FDLE VECHS Waiver Agreement & Statement**.
THIS FORM MUST BE MAILED OR HAND DELIVERED, IT CANNOT BE SCANNED OR FAXED!

- Submit the FDLE VECHS waiver to:

Colleen Alcantara-Slocombe
Florida Atlantic University
C/O Christine E. Lynn College of Nursing
777 Glades Road, NU 349
Boca Raton, FL 33431

To initiate the Background Check process, proceed to www.certifiedbackground.com. This process involves a Drug Test, Fingerprinting, Background Check, and Immunization, *which is mandatory*.

- a. All associated fees and costs are the responsibility of the applicant/student. The cost will be a one-time fee of \$154.00. The cost to continue using the Trackers is an additional \$10/year which may be necessary depending on your enrollment in a program but optional otherwise.
- b. Any forms needed to complete items your health record system will be available to download directly from your health record account.

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IMPORTANT NOTES

Licensure: It is important to note that admission to and completion of a program at the Christine E. Lynn College of Nursing ***does not guarantee*** that the Florida State Board of Nursing (or any other licensing body) will grant eligibility for licensure.

Information can be found at their website: www.doh.state.fl.us/mqa/nursing/.

Drug Screening: is required at the time of admission as well as *additional screenings* throughout *the program*, especially if a clinical agency mandates it.

Background Check: In the event that an applicant's background check indicates a history that might prevent participation in a nursing practice component of the program, the Program's Dean will consider the applicant's individual situation and make a decision about admission in the program.

If the background check and drug screening results are unsatisfactory, the student may be denied admission to a clinical agency and/or access to patients in the agency. *If a comparable assignment cannot be made to meet the course objectives, the academic requirements of the program cannot be met. The student will be denied progression in the College of Nursing, resulting in withdrawal of dismissal from the program.*

Self-Insurance Plan (SIP) requirements: Florida Atlantic University has a Self-Insurance Program which covers all of our nursing students during practicum experiences. Please be aware that the college SIP only covers you in the role of the student.

You are required to complete the SIP 101 online training program located at: <http://flbog.sip.ufl.edu/cme/> (Please click on the FAU logo on the right hand side of the screen). Be sure to register as a **FAU Student** before beginning the training, to access the required completion certificate.

For additional information regarding Background Checks, Drug Screens and Immunization, please contact **Colleen Alcantara-Slocombe** at 561-297-6261 or slocombe@fau.edu.

For technical, sign-on questions and issues please contact **Certified Background** directly at (888)666-7788 or email at customerservice@certifiedbackground.com.

Christine E. Lynn College of Nursing
Florida Atlantic University
Detailed Instructions to Complete Certified Background Application

DOCTORAL PROGRAM

The process begins at www.certifiedbackground.com

In the “Order Now” section of the main page (on the Right side of the page), click “Students”

Step 1 Set up your Certified Account

1. Enter your Package Code **FL08**
2. Please read the overview of the requirements.
3. Click the check boxes to all 3 “Terms and conditions” at the bottom of the page
4. Click the box for “e-mail” as your ID (**Please use your FAU email**)
5. Select your password and icon (a picture that is meaningful to you). This provides an added level of security to your account.
6. Complete the personal information on this page.
7. Create your access code using your **FAU e-mail address** and a password.

Step 2 Background Check

1. Complete requested information regarding county criminal background check.
2. Complete employment history (only the **red** star information is required).
3. Click “No” in response to the badge offer. FAU does **NOT** recommend you purchasing it
4. Review the order. (**Cost \$154**)
5. Enter payment information.
6. Click “Next” if ready to continue to the Disclosure and Authorization Release.
7. Click “**e-sign release**”.
8. **Type in your full name in “Notes” box and Click submit.**

Step 3 Fingerprinting

1. Please log on to www.L1Enrollment.com
2. Select the state of **Florida**.
3. Choose **Online Scheduling**.
4. Select English or Espanola.
5. Enter your first and then last name.
6. From the drop down menu please select “**VECHS**”
7. Choose **Volunteer**.
8. Enter your **OCA number 50020009**.
9. On the location page **ENTER YOUR ZIP CODE**.
10. Select an appointment date/time.
11. Fill out your demographic data (at any time please **do not enter all “zeros” for Social Security number**).
12. Once you review and/or revise your information, click “Finalize Appointment”.
13. Select **BILLING ACCOUNT** as your method of payment; enter the billing code **FLCB00100**
14. Hit “Send Information”.
15. **Print your confirmation page.** (You must take this page with you, when you go to take your finger prints).

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Detailed Instructions to Complete Certified Background Application

DOCTORAL PROGRAM

Step 4 Schedule for Drug test

1. Register for drug testing.
2. Locate a Lab Corp specimen collection site at <https://www.labcorp.com/ots/locator.do>.
3. Enter the 9 digit **(code given begins with 107-)** in the **Registration Number** field. This number will be sent to you in an email 24hrs after you register for the drug test.
4. **Print and present the registration page AND a government issued photo ID at the Lab Corp collection site.**

Step 5 Scan files for tracker

(Please go to the <http://nursing.fau.edu/index.php?main=3&nav=713> for any forms that you may need.

1. Scan the following to upload:
 - a. **Immunization Form – to include the mandatory Vaccines**
 - i. Varicella
 - ii. Hepatitis B (*or* waiver)
 - iii. MMR (Measles, Mumps or Rubella)
 - iv. Influenza (*or* waiver)
 - v. Tetanus & Diphtheria w/in 10 years (Tdap)
 - b. **Annual Student Health Form/TB skin test (1 step or Chest X-ray)**
 - c. **Health Insurance Card.**
 - d. **Student Acknowledgement of Background Check Policy.**
 - e. **RN License.**
 - f. **Clinical Guidelines Acknowledgement.**
 - g. **CPR Card (copy of the FRONT and BACK).**
 - h. **Student Handbook Acknowledgement Form.**
 - i. **Clinical Site Information Sharing Authorization/Approval Form.**
 - j. **Health Insurance Portability and Accountability Act (HIPAA) Requirements.**
 - k. **Photo/Media Release Authorization.**
 - l. **Self-Insurance Plan (SIP) Certificate. <http://flbog.sip.ufl.edu/cme/>**
2. Once you have your files saved on your computer, you are ready to upload to Magnus.

Step 6 Magnus Tracker

3. Click Begin Magus from the “To-Do-List” page.
4. Click the **orange** link to “Accept terms and conditions” then click “continue”
5. Enter the semester that **you plan to start.**
6. In the upper left corner of the next page, click the **blue** “Upload new record” link.
7. Click the item you want to upload (for example your CPR card).
8. Click “Browse” to find the CPR card from your computer file.
9. Click “Upload”
10. Name your record you are uploading.
11. Check to **be sure the right document is connected to the right file.**

How to return to your “To-Do-List” page after signing out

Go to www.certifiedbackground.com

In the **teal colored** “View your results” box on the right had side of the page, enter the e-mail address you are using for the system. Click “View” and you will be taken directly to your “To-Do-List” page.

Immunity Criteria

To be in compliance with the mandatory immunization requirements, students **must provide documentation** of numbers 1-7 that follow. Information submitted will be compiled on the Certified Background.com

1. Measles
 - a. Born before December 31, 1956; **or**,
 - b. Laboratory evidence of immunity; **or**,
 - c. Immunization with two doses of measles vaccine after the first birthday with at least 30 days between doses.

2. Mumps
 - a. Born before December 31, 1956; **or**,
 - b. Health care provider-diagnosed mumps; **or**,
 - c. Laboratory evidence of immunity; **or**,
 - d. Immunization with 2 doses of mumps vaccine on or after the first birthday.

3. Rubella
 - a. Laboratory evidence of immunity; **or**,
 - b. Immunization with 2 doses of Rubella vaccine on or after the first birthday.

4. Tetanus and Diphtheria/(Td) or Tetanus/Diphtheria/Pertussis (Tdap)
(commonly called Tetanus)
 - a. Record of booster every 10 years

5. Hepatitis B (HBV)
 - a. A series of three doses of vaccine is required ; **or**,
 - b. Evidence of Hepatitis B vaccination series in process, with completion of series by the start of the second semester of study in the College of Nursing; **or**,
 - c. Laboratory evidence of Hepatitis B immunity.

6. Tuberculosis
 - a. Annual PPD skin test with negative reactivity; **or**,
 - b. Results of ONE chest x-ray and medical follow-up for those with past history of positive reactivity. A chest x-ray is NOT annual and it should never be completed annually. Individual IS compliant if they have one chest r-ray at any point in history following a positive PPD.

7. Varicella
 - a. Born before December 31,1956; **or**,
 - b. Health care provider-diagnosed history of disease; **or**,
 - c. Completed vaccinations with a series of two doses; **or**,
 - d. Laboratory evidence of immunity.

Florida Department of Law Enforcement
Criminal Justice Information Services Division/User Services Bureau



VECHS WAIVER AGREEMENT AND STATEMENT
Volunteer & Employee Criminal History System (VECHS)
For Criminal History Record Checks
Under the National Child Protection Act of 1993, as amended,
And Section 943.0542, Florida Statutes

Pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes, this form must be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize **FLORIDA ATLANTIC UNIVERSITY** to submit a set of my fingerprints and this form to the **Florida Department of Law Enforcement** for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I chose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer, pursuant to the national Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes.

I understand that, until the criminal history background check is completed, you may chose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, you will provide me a Copy of the criminal history background report. If any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

A national criminal history background check on me has previously been requested by:

(Name and Address of Previous Qualified Entity) (Year of Request)

I ____ have **OR** ____ have not been convicted of a crime.

If convicted, describe the crime (s) and the particulars of the conviction (s) in the space below:

I ____ do **OR** ____ do not authorize you to release my criminal history records, if any, to other qualified entities.

I am a current or prospective (check **one**): Employee Volunteer Contractor/Vendor

Signature: _____ Date: _____

Printed Name: _____

Address: _____

Date of Birth: ____/____/____

TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: **Florida Atlantic University**

Address: **777 Glades Road**
Boca Raton, FL 33431

Return to: Colleen Alcantara-Slocombe
C/O Credentialing Office, NU 349

Telephone: **561-297-2872**

FDLE Assigned Qualified Entity Number: **E 500 200 09 V 500 200 09**

ORIGINAL—MUST BE RETAINED BY QUALIFIED ENTITY



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Immunization Form

THIS FORM MUST BE UPLOADED INTO MAGNUS

Date: ___/___/___

Name: _____

Z Number: _____

Academic Program: _____

Student Attestation: I confirm that the information provided on this form is the most recent and accurate information. **I understand that I am solely responsible for making sure I have all immunizations needed, they are current each year,** and that any costs associated with it are my responsibility.

Student Signature: _____

**The following immunizations need to be provided once (at initial submittal).*

They need to be updated yearly or you need to watch the expiration date and revise these sections annually as needed.

*If you choose/need the Hepatitis B Waiver, write, "waiver" in the box and **make sure to provide the waiver form with this health form.***

PLEASE SUBMIT A COPY OF LAB RESULTS, HEALTH RECORDS OR HEALTHCARE PROVIDER VERIFICATION.

VACCINE	DATE (S)	RESULT (S)
Varicella		
Hepatitis B (or waiver)		
MMR (Measels, Mumps or Rubella)		
Influenza (or waiver)		
Tdap (w/in 10yrs) (Tetanus)		

 NAME OF HEALTH CARE PROVIDER (PRINT)

 FLORIDA LICENSE

 SIGNATURE OF HEALTH CARE PROVIDER

OFFICE ADDRESS (STAMP)



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HEPATITIS B IMMUNIZATION WAIVER

THIS FORM MUST BE UPLOADED INTO MAGNUS

Name: _____
(PRINT)

Z# _____

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.

I have been informed of the advantages of having the HBV vaccination, and have decided to not be vaccinated, and **I accept the risks to my own health.**

Signature: _____

Date: _____

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ANNUAL INFLUENZA VACCINE WAIVER
THIS FORM MUST BE UPLOADED INTO MAGNUS

Name: _____
(PRINT)

Z#: _____

I understand that due to my occupational exposure to potentially infectious materials I may be at increased risk of acquiring the flu.

I have been informed of the advantages of having the flu vaccine, and I have decided not to be vaccinated, and I accept the risks to my own health.

I understand that I will be required to meet individual agency requirements which may include wearing a mask or having limited access to patient population.

Signature: _____

Date: _____



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Annual Student Health Form

THIS FORM MUST BE UPLOADED INTO MAGNUS

Date: ___/___/___ Name: _____

Z Number: _____ Academic Program: _____

Statement from MD/ARNP

IN MY OPINION, THE ABOVE NAMED PERSON IS FREE OF COMMUNICABLE DISEASE AND HAS THE CAPABILITIES TO PERFORM THE DUTIES REQUIRED OF A STUDENT IN THE CHRISTINE E. LYNN COLLEGE OF NURSING.

VACCINE	DATE (S)	RESULT (S)
TST (required yearly) if negative history (TB Skin Test) -OR-		
If TST Positive a CXR dated within 6 months prior to starting nursing program. (No yearly requirement)		

*Additional requirements, such as but not limited to the flu vaccine, may be required by individual facilities.

COMMENTS: _____

Student can attend () **or** cannot () attend class.

 NAME OF HEALTH CARE PROVIDER (PRINTED)

 FLORIDA LICENSE

 SIGNATURE OF HEALTH CARE PROVIDER

OFFICE ADDRESS (STAMP)



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STUDENT ACKNOWLEDGEMENT OF BACKGROUND CHECK POLICY

I understand the Policy regarding Oath and Affirmations in relation to keeping my Background Check valid. As stated in the College of Nursing website, www.fau.edu/nursing, and the College of Nursing's Graduate/Undergraduate Handbooks:

1. *The Christine E. Lynn College of Nursing requires the annual submission of a signed and notarized Oath and Affirmation statement indicating that the student **has not been arrested or charged with any crime or misdemeanor since the date of the initial background check.** However, some agencies may require annual background checks and will not accept the Oath and Affirmation statement.*
2. *"If the student experiences a break in enrollment of one or more calendar year(s) from the original background check or most recent oath and affirmation statement, a new complete background check (both components) will be required before the student may resume course-work."*

As a student in the Florida Atlantic University Christine E. Lynn College of Nursing, I understand that it is **my responsibility** to:

- a) Make sure that **this form is uploaded** with my Medical Health Records (where it states "Student Acknowledgement of Background Check Policy"), into the MAGNUS system, **immediately after my initial background checks.**
- b) **Before the one year anniversary of my initial background check upload** the Notarized Student Oath & Affirmation form into Magnus.
Otherwise, I understand I will be required to repeat the background check process.

Z NUMBER: _____ DATE: _____

PRINTED NAME: _____

STUDENT SIGNATURE: _____

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CLINICAL GUIDELINES ACKNOWLEDGEMENT
THIS FORM MUST BE UPLOADED INTO MAGNUS

Printed Name

Date

Before you will be allowed to attend advanced practice experiences for the College of Nursing, students in **any** advanced nursing site are required to read the Safety Guidelines for Clinical Practice information and **sign this form.**

I have read and understand the following guidelines:

(Please answer **yes** or **no** in the space by each)

1. Safety in Community Settings _____
2. Critical Incidents _____
3. Universal Precautions _____
4. Blood Borne Pathogens _____

Signature

Z#

Address

City

State

Zip

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STUDENT HANDBOOK ACKNOWLEDGEMENT FORM

THIS FORM MUST BE UPLOADED INTO MAGNUS

I _____ have read and aware that FAU catalogs are found online at www.fau.edu and the **Christine E. Lynn College of Nursing** Student Handbook is found online at <http://nursing.fau.edu>.

I agree to follow the guidelines set forth in the university catalog and the **Christine E. Lynn College of Nursing** Student Handbook appropriate to my program.

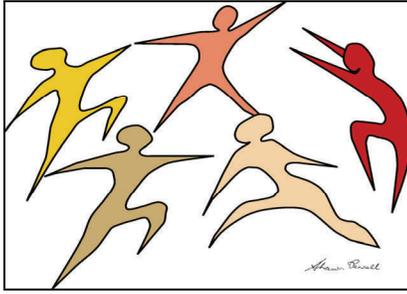
Also, I understand that I am responsible for checking my FAU emails on a weekly basis.

PRINTED NAME

Z#

SIGNATURE

DATE



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Clinical Site Information Sharing Authorization / Approval Form

THIS FORM MUST BE UPLOADED INTO MAGNUS

As a nursing student enrolled in courses with the **Christine E. Lynn College of Nursing** at Florida Atlantic University, I permit faculty and representatives of the college to share my name, phone number and home address with clinical agencies for facilitating my placement in nursing practice courses.

I also agree that FAU may share any background reports or findings with any agency or hospital where I may complete my clinical/educational requirements.

In the event that an applicant's background check indicates a history that might prevent participation in a nursing practice component of the program, the Program Director will consider the applicant's individual situation and make a decision about admission in the program.

If the background check or drug screening results are unsatisfactory, the student may be denied admission to a clinical agency and/or access to patients in the agency. If a comparable assignment cannot be made to meet the course objectives, the academic requirements of the program cannot be met. The student will be denied progression in the College of Nursing resulting in withdrawal or dismissal from the program.

I understand that by my signature, this authorization is granted for the duration of my undergraduate program at the **Christine E. Lynn College of Nursing**.

Printed Name

Date

Signature

Student ID/ Z#

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HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA) REQUIREMENTS

THIS FORM MUST BE UPLOADED INTO MAGNUS

I, _____ have reviewed the
(PRINT NAME)
required HIPAA educational materials provided by the Christine E. Lynn College of Nursing and
understand compliance regulations governing the protection of client's confidential health care
information.

SIGNATURE

DATE

Z#

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PHOTO / MEDIA RELEASE AUTHORIZATION
THIS FORM MUST BE UPLOADED IN MAGNUS

I, the undersigned, do () *or* do not () hereby voluntarily participate and give authorization for _____ to appear in filming, for photographs, videotaping _____
(Name or “myself”)
and / or interviews for publications or radio, television, newspaper or magazine for both stated and unforeseen purposes and authorize the disclosure of my identity in the use of said photographs and / or interviews.

I do hereby release Florida Atlantic University, its agents and its employees from all liability in connection with the above. I waive any right to inspect or approve the finished product or other copy that may be used in connection with the above and waive any monetary compensation to me now or in the future. This shall be binding upon my heirs, personal representatives and assigns.

PRINTED NAME

DATE

SIGNATURE

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