THE CATHOLIC UNIVERSITY OF AMERICA | Conway School of Nursing

Washington, D.C. 20064
202.319.5400

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 nursing clinical rotation at the present time.

_____ Limitations which include: _____
(examples: Medical conditions, Mental conditions, or chemical dependence; 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 June 2012

***DO NOT SUBMIT TO SON, SUBMIT TO CERTIFIEDBACKGROUND.COM