Your Educational Partner of Choice
BOCES 2 Center for Workforce Development

MONROE 2–ORLEANS BOCES · CWD Center for Workforce Development · ENGAGE EDUCATE EMPOWER

Instructions for Completing the Medical Clearance Form

The Medical Clearance Form is required for ALL students participating in the BOCES 2 CWD Nurse Assisting Program

As mandated by New York State Office of Professions, **participants must complete and submit the Medical Clearance Form no later than March 1st.**

Below are the steps to help you complete the Medical Clearance Form:

1. **Schedule your Medical Appointment:** The Medical Clearance Form must be completed by your primary care doctor or another physician **by March 1**, and no sooner than one year prior to the ***clinical*** start date.

   Students without a primary care physician may schedule an appointment at an urgent care facility that performs work physicals, such as WellNow Urgent Care Clinic at 2232 Lyell Ave, 585-417-4125.

   Please note there may be a fee for the primary care or other physician appointment, vaccines, or tests at your primary care office or other health care clinic.

2. **Complete and submit the Medical Clearance Appointment Confirmation Form** (page 2) with attached proof of appointment before the first day of class. *This form may be uploaded to your account or emailed to CWDInfo@monroe2boces.org.*

3. **Attend appointment to complete the Medical Clearance Form** (pages 3 and 4) **and confirm all fields of the fields are 100% complete: ALL FIELDS** on the Medical Clearance Form must be filled out **by your doctor(s)** and submitted by December 1 to participate in the "clinical" portion and successfully complete the program.

4. **Ensure the Medical Clearance Form is properly signed.** It is **required** that the Medical Clearance Form **is signed**, **dated, and stamped by your doctor(s)** to be accepted and your clinical participation approved by BOCES 2 CWD.

5. **Keep a copy for your records.** It is **recommended** that you pick up the original Medical Clearance Form from your doctor(s) and make a copy for your records prior to submitting it.

6. **Submit the Medical Clearance Form to BOCES 2 CWD:** It is **recommended** that you drop off the medical form at the BOCES 2 Center for Workforce Development, 3589 Big Ridge Road, Spencerport, NY 14559. *You may also fax, email, or upload the form to your student account or provide consent for your doctor(s) to fax the Medical Clearance Form to BOCES 2 CWD, ATTN: Admissions*

   Email: CWDInfo@monroe2boces.org Fax: (585) 349-9101

IMPORTANT

It is YOUR RESPONSIBILITY to ensure that the Medical Clearance form is completely filled out, signed, dated, and stamped by your doctor(s), and submitted to the BOCES 2 CWD Office by December 1. Failure to submit the completed form may result in dismissal from the program.

If you have any questions, please do not hesitate to call us at (585) 349-9100 for assistance.

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Medical Clearance Appointment Confirmation Form

Complete and submit this form by the first day of class.

Be sure to include proof from your doctor's office confirming your scheduled appointment.

Submit by the first day of class

Student Name: ____

Program: ______________________________ Start Date: ________________

This form certifies that you have scheduled a doctor's appointment to have your medical clearance form completed.

Date of Appointment: ___________________ **Time:** ______________________

Name of Physician: ____

Physician Office/Practice Name: ___________________________________

Physician Office Address: ____

Physician Phone Number: ____

Attach proof from your doctor's office confirming your scheduled appointment

Acceptable proof includes a copy of the appointment card, letter, or note from the doctor.

Student Signature: _________________________________ Date: ______________

IMPORTANT

By completing this form and signing above, you understand that your ***Medical Clearance Form*** *must be completed and all vaccine and test requirements fulfilled* ***no later than March 1st*** *or you will not be eligible to participate in clinical which could result in dismissal of the program.*

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Nurse Assisting - Medical Clearance Form

Submit by March 1st

Student Name: ____________________________________ **DOB:** ______________________________

Student Address: ____

Telephone Number: __________________________ **Email:** _______________________________________

Latex Allergy: _______ **Yes** _______ **No**

Allergies: ____

Medication & Supplements (List All) _______ **None**

____

____

Date of Exam *(must be completed within 1 year of clinical start date)*	**Height**	**Weight**	**Blood Pressure**	**Pulse**

Please circle findings. Comment only if abnormal.

Hand/skin: normal / abnormal

Comment: ____

Head/eyes: normal / abnormal

Comment: ____

Ears/nose/throat/mouth: normal / abnormal

Comment: ____

Neck/nodes: normal / abnormal

Comment: ____

Chest/lungs: normal / abnormal

Comment: ____

Cardio/vascular: normal / abnormal

Comment: ____

Abdomen: normal / abnormal

Comment: ____

Musculoskeletal/extremity/spine: normal / abnormal

Comment: ____

Nervous system/seizure disorder: normal / abnormal

Comment: ____

Genito/urinary: normal / abnormal

Comment: ____

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Name: ______________________________ **Program:** ______________________

IMMUNIZATIONS: Please indicate the date of Vaccination and Lot number or proof Titer

Administered Dates	**#1**	**#2**	**#3**	**#4**	**Required or Optional?**
MMR (Measles, Mumps, Rubella)	Date: Lot #	Date: Lot #			**REQUIRED**
~~Vacarella~~Varicella	Date: Lot #	Date: Lot #			**REQUIRED**
HEP B Vaccine (series)	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	**REQUIRED**
Sars-Cov-2 Vaccine	Date: Lot #	Date: Lot #	Date: Lot #	Date: Lot #	*Optional*
Influenza Vaccine (seasonal)	Date: Lot #				*Optional* ***highly recommended*** *(masking required if not complete)*
PPD SKIN TEST Date Placed:	Date Read:	Read By:	Lot #	Results:	**REQUIRED**

Positive PPD, chest X-ray results: (circle one): Normal / Abnormal Date: ______________________
(Mo/Day/Yr)

Does this patient suffer from any chronic physical or mental disabilities and or limitations that would interfere with patient care for a period of 6 hour to 12 hour working days? _______ Yes _______ No

If YES, please explain: ____

____

To the best of my knowledge the above-named patient has been medically cleared to participate in clinical work and/or education at this time.

Physician's Name: ______________________________ **NPI #:** ____________________
Print

Physician's Signature: ______________________________ **Date:** ____________________
Sign

Physician's Office Stamp: