Nursing Competency Assessment Programme

Doctors' Name:

Doctor's qualifications (official stamp if any):

Doctor's address:

Doctor's phone number:

Doctor's email address:

Declaration:

Based on examination of (applicant name) …… of (address) ……, their medical history, patient record and interpretation of immune status results (including Xray result* if required), I find that (applicant name) …… poses no risk to self or patients by undertaking practical work experience/nursing in an acute/tertiary/community healthcare institution in New Zealand.

Signature:

Medical Practitioner Name:

Date:

(NOTE: this form is to be signed by the Doctor only)

*Xray only indicated where Quantiferon TB-Gold test positive

Dear Applicant,

To apply for the **Nursing Competency Assessment Programme** (or alternative), you are required to submit a health clearance. Please have this form completed by a doctor and send it back to us along with your application forms. Please be advised that your application ***will not*** be processed until we receive your completed medical results.

Title:	Surname:	First Names:
Date of Birth:	Programme you are enrolled in:	

Please Note: All sections must be completed - Not applicable does not apply to any of these questions. If immune; vaccination not required. If non-immune; student should start vaccination course.

For COVID 19, please include evidence of your covid vaccinations.

Disease	Vaccination 1 Date	Vaccination 2 Date	Booster Date
Covid 19			

NOTE: This health clearance includes evidence of immune status (NOT immunisation status) for the following:

Disease	Immune	Not Immune & Date vaccination commenced
Measles		
Mumps		
Rubella		
Chicken Pox		
Hepatitis B		

Please circle the correct response for the applicant:

Tuberculosis	No evidence of active pulmonary TB disease		**Positive Quantiferon result:** Referred & Chest X as per protocols
Pertussis	Not Tested	No booster in the last ten years	**Date given:**
MRSA Clearance	Does not fit risk criteria for testing	Swab negative	**Swab positive: follow up**

The above information is accurate and reflects the immune status of the student named above

Dr/Nurse Name:_____Signature:_____Date:___/___/____

Name Practice / Health Centre _____

Student Consent

I_____consent to the release of this information, as needed, by Clinical supervisors in my programme and placement institution. I understand that this information is required to manage my health and safety and that of the people that I may come into contact with during my training.

Student Signature_____Date:___/___/____

Please include a copy of all relevant blood tests when submitting this form to the Programme Administration Team