# Nurse Fellowship Program/Requirement Verification

Name ______________________ Phone # ______________________

Email ______________________ Facility ______________________

Date(s) of experience ______________________ Date of Birth ______________________

Emergency Contact ______________________ Emergency Phone # ______________________

**This form is to be completed by an authorized facility representative.**

| Name_______________________________ Please Print First and Last Name | Date Reviewed | Facility Representative Initials |
|---|---|---|
| 1. **Immunizations:** I am verifying that the information on the nurse's immunization verification form has been obtained from the nurse's records on file with the facility. | | |
| 2. **Background Check**: I verify that a criminal background check, exclusion list check from Office of Inspector General (OIG) http://exclusions.oig.hhs.gov/ and national sexual offender registry search http://www.nsopw.gov/en-us has been completed on this nurse. I am verifying that the results show no records and/or no discrepancies. This is required unless other arrangements have been made in advance with Community Medical Center. | | |
| 3. **Random Audits:** I understand Community Medical Center will conduct random audits of the above information. Failure to comply with all requirements or not have complete records on file for a nurse may result in termination of the Registered Nurse Fellowship Program for one or all nurses from this facility. | | |
| • **Drug Screen:** I am verifying that the information on the student's 10 panel drug screen is no more than **30 days** from the start of the school year; I am verifying that the results show no discrepancies | | |
| 5. I verify the nurse has a current Montana State License and is in good standing with the Montana State Board of Nursing. | | |
| 6. I verify the nurse has a current BLS Healthcare Provider certification. | | |
| 7. I verify the above statements to be true. I have reviewed and understand all the information that has been given to the nurses in the Registered Nurse Fellowship Checklist and Orientation Manual. | | |

Authorized Facility Rep Signature_________________________________ Date ______________________

Print Name_________________________________________________ Phone # ____________________

Email address______________________________________________