Dear Nursing Student,

It is my pleasure to welcome you on behalf of the faculty and staff of the Nursing Program to Bergen Community College. I wish you success in your professional and personal goals. To that end, myself, the faculty, and staff are committed to assist you as you begin this incredible journey culminating in your entry into the profession of nursing.

This nursing program prepares its graduates to become leaders of tomorrow by integrating classroom content with real life patient interactions in a variety of healthcare facilities. The program uses cutting edge technology such as the Human Patient Simulator to provide simulated experiences. This amazing learning tool enables you to practice your clinical skills before embarking into the clinical areas.

Graduates of the Bergen Community College Nursing Program are sought after by every healthcare facility in the college’s service area. Graduates of the program consistently report that they “were extremely well prepared to begin their nursing career”. Other indicators of success is that the program is fully accredited by the National League for Nursing Accreditation Commission and the New Jersey Board of Nursing.

Your future begins here and now. Best wishes for success.

Sincerely,

Dawn Kozlowski, PhD, RN, CNE
Associate Dean of Nursing
Dear Nursing Student:

Congratulations on your acceptance to the Nursing Program at Bergen Community College. We look forward to welcoming you personally to the program.

The following requirements must be completed and submitted IN PERSON TO THE NURSING OFFICE - ROOM B-302 by July 14, 2014

- **Complete Health Service Record**
  These forms must be filed with the Office of Health Services, Room HS100. You will be given a ‘Clearance Form’ from Health Services once you have met all the medical requirements. **Submit the original blue form to the Nursing Office.**

- **Obtain Malpractice Insurance**
  Nursing students are required to purchase liability insurance. You can purchase the insurance from any company. You can also apply online at [www.nso.com](http://www.nso.com) or you can call toll free 1-800-247-1500.

- **Obtain certification in CPR (cardio-pulmonary resuscitation) ONLY FROM:**
  The American Heart Association. It **MUST** be for BLS/Healthcare Provider.
  **OR**
  The American Red Cross, CPR/AED for the Professional Rescuer and the Healthcare Provider Certification.

- **Signed “NURSING STUDENT HANDBOOK POLICY SIGN-OFF FORM”**

  **CARDS ISSUED BY OTHER INSTITUTIONS OR ASSOCIATIONS WILL NOT BE ACCEPTED.**

Proof of completion of a **live course** must be submitted by the deadline. It takes a few weeks to receive the official CPR card. Upon completion of the class, obtain a letter from your instructor stating that you have successfully completed the class. When you receive your card, please **make a copy** of the card. Copies can be made in the College Library.

Class schedules are available online at the American Heart Association website, [www.americanheart.org](http://www.americanheart.org) and the American Red Cross website, [www.redcross.org](http://www.redcross.org). The Bergen Community College School of Continuing Education also offers CPR classes. Classes are listed in the Continuing Education catalog. You can pick up a copy of their course catalog in the Technology Building or you can call them at 201-447-7488 for more information.

**ALL OF THE ABOVE ARE MANDATORY CLASS AND CLINICAL REQUIREMENTS FOR NURSING STUDENTS. STUDENTS WILL NOT BE PERMITTED TO ATTEND CLASS OR CLINICAL WITHOUT THESE DOCUMENTS.**

Sincerely,

Dawn Kozlowski, PhD, RN, CNE
Associate Dean of Nursing

**SAVE THE DATE**
**ORIENTATION – JUNE 25, 2014**
BERGEN COMMUNITY COLLEGE
HEALTH SERVICES RECORD
OFFICE: 201-447-9257 FAX: 201-447-0327

Last Name (Please Print) ___________________________ / _____________ / _____________ M / F ______ (circle) Social Security #
Address: Street ___________________________ / _____________ / ___________________________ ___________________________ / _____________ / _____________ / _____________
Telephone Home: __________________ Work: __________________ Cell: __________________ Date of Birth: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:
Name _____________________________________________________________________________________
Telephone Home: __________________ Work: __________________ Cell: __________________ Date of Birth: _____

Part A: Student To Complete
1. Head injury / fainting / seizure ___________________________ / ___________________________ / ___________________________
2. Eye injury/loss of vision ___________________________ / ___________________________ / ___________________________
3. Broken bone ___________________________ / ___________________________ / ___________________________
4. Hospitalization or surgery ___________________________ / ___________________________ / ___________________________
5. Diabetes, Heart, Lung, Asthma, Cancer, or other serious illness ___________________________ / ___________________________ / ___________________________
6. Anxiety / emotional / mental illness ___________________________ / ___________________________ / ___________________________
7. Other health problems ___________________________ / ___________________________ / ___________________________
8. Allergies: food/ medications / environmental ___________________________ / ___________________________ / ___________________________
9. Take any medications regularly ___________________________ / ___________________________ / ___________________________

Part B: Health Care Provider/Physician Complete: Please indicate immunizations with dates. If an immunization is not given for medical reasons, please attach signed statement with reason for exemption.

Immunizations: MMR#1, MMR#2 and Hepatitis B vaccine series are minimum requirements for full-time BCC students.

Vaccine Mo/Day/Yr Blood test/titer (if applicable) Exemptions – other than medical
MMR#1 (age 1yr or older)
*MMR#2 (30 days after#1)
Measles ____________ Measles IgG: ____________ Date: ____________.
Mumps ____________ Mumps IgG: ____________ Date: ____________.
Rubella ____________ Rubella IgG: ____________ Date: ____________.
Hepatitis B Vaccine 1. ____________ 2. ____________ 3. ____________ or HepB surface antibody titer or anti-HBs titer
If test/titer is negative, you must be vaccinated. (copies of lab reports must be attached)

CENTER FOR DISEASE CONTROL RECOMMENDS:
Tetanus: Td / Tdap (circle one) within 10 years Date: ____________ Mantoux: Date ____________ Results ____________ mm
Meningitis 1. ____________ 2. ____________ Menactra ____________ Varicella vaccine 1. ____________ 2. ____________

MANDATORY for All Nursing and Health Professions ONLY

MMR and Hepatitis B requirements as above.
Td / Tdap (circle one) Date of last Booster: (must be within 10 years) Date: ____________
Varicella (Chicken pox) IgG blood test (titer): ____________ (Copy of lab report must be attached)
OR Varivax Dose#1 ____________ Dose#2 ____________ (4 to 6 weeks apart) (Varivax required if titer is negative)
TB test: PPD skin test OR Q-Gold blood test date within 6 months of starting program: PPD results Neg ( ) Pos ___ mm.
If PPD or Q-Gold result is positive, Chest x-ray required within 1 yr. of starting program. Copy of Q-Gold lab report is required.

Name of Health/Medical Insurance Company/Group and Address ____________________________
Policy or Group # ______________________ expiration date ______________________ (copy of card must be attached)

Signature: Health Care Professional/Physician Stamp/Address ____________________________ Date ____________
NOTE: NURSING AND HEALTH PROFESSIONS STUDENTS ONLY:
THIS MEDICAL EXAM MUST BE RETURNED TO HEALTH SERVICES BEFORE STARTING CLASSES IN ORDER TO
BE CLEARED FOR CLINICAL. MEDICAL EXAM MUST BE DATED WITHIN 6 MONTHS OF STARTING YOUR
PROGRAM

ID#___________________

Email Address: _______________________________

BCC HEALTH SERVICES MEDICAL RECORD
OFFICE: 201-447-9257 FAX 201-447-0327

Part C/page 2 Health Care Provider/Physician complete:

Patient's Name: ________________________ Date of Birth: ____________________ Date: ____________________

Address: Street __________________ City __________________ State __________________ Zip Code __________________

Emergency Contact: Name __________________________________ Telephone ______________________

Height: ________ Weight: ________ Blood/Pressure: ________ Pulse: ________ Respirations: ________ Temp: ________

Allergies: __________________________________ Medications: ____________________

General Appearance: ___________________________________________

Review of Systems:

<table>
<thead>
<tr>
<th></th>
<th>Norm</th>
<th>Abnor</th>
<th>Comments/ Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin (acne, fungi infection)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head/Neck (masses, range of motion, pain on motion)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Glands (cervical, axillary, inguinal)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Eyes (conjunctiva, jaundice)</td>
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</tr>
<tr>
<td>Ears (infection, perforation, hearing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose (obstruction)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Teeth/Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs (chronic bronchitis, asthma)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Heart (murmurs, click, rhythm)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Abdomen (Liver, spleen, masses)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Back (deformity, range of motion, scoliosis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities (range of motion, deformity, weakness, scars)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological (reflexes, balance, coordination)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Abnor

Clinical Impression based on history and physical exam: _____________________________________________

Recommendations: For this student:

____ May participate in physical activities

____ Needs health problems evaluated prior to participation in physical activities

____ Health problem limits participation in physical activities: ______________________

____ Limit classroom and physical activities as follows: __________________________

Comments or Recommendations: _____________________________________________

___________________________________________________

Signature: Health Care Professional/Physician: ________________________ Date: ________

Health Care Address Stamp

Rev 4/13
Incoming Nursing/Health Professions Students – Tuberculosis (TB) Screening Requirement

**Part A** must be completed by you. **Part B** must be completed by your physician or healthcare provider. Please return the completed form to The Office of Health Services, HS-100, Pitkin Education Center.

**Part A**

Name:________________________________________________ Date of birth: ______________

Student ID: __________________________ Email address:_____________________________________

Home Phone:________________________ Cell Phone:______________________

**Part B**

**Tuberculosis (TB) Screening:** In order to be cleared for clinical participation, you are required to submit the date and results of either a PPD skin test OR an interferon gamma release assay (IGRA) blood test such as Quantiferon Gold.

* A 2-Step PPD skin test is necessary unless a PPD was done within the past calendar year.* If a 1-Step PPD was done within the past calendar year, documentation must be entered below. If an annual PPD was missed, a 2-Step PPD skin test must be done within 6 months of starting your program.

PPD(Mantoux) #1:_________ (date administered) _________ (date read 48-72 hrs. after injection)

Results:   positive_________   negative (circle one); report positive results in millimeters.

PPD(Mantoux)#2:_________ (date administered) _________ (date read 48-72 hrs. after injection)

Results: positive__________   negative (circle one); report positive results in millimeters.

OR

Quantiferon Gold blood test may be used in place of PPD – Lab report must be attached

______________ (date of test) Result: positive   negative (circle one)

Chest X-ray is required if PPD or Q-Gold result is positive. Chest X-ray must be performed within 6 months of starting program. Chest X-ray report must be attached.

If result of the Q-Gold blood test is indeterminate, repeat Q-Gold or administer PPD skin test.

Signature of physician or healthcare provider:_______________________________ Date:__________

Healthcare Address Stamp:

Rev 4/13
DIVISION OF HEALTH PROFESSIONS

Department of Nursing

CPR CERTIFICATION

ALL NURSING STUDENTS ARE REQUIRED TO MAINTAIN CPR CERTIFICATION FROM THE FOLLOWING ORGANIZATIONS ONLY:

**American Heart Association**
BLS for Health Care Provider Certification

**OR**

**American Red Cross**
CPR/AED for the Professional Rescuer and the Healthcare Provider Certification

A photo copy of your CPR Certification card must be submitted to the Nursing Office Secretary – Room B-302 by July 14, 2014

Proof of completion of a live course must be submitted to the Nursing Department Secretary by the deadline. It takes a few weeks to receive your official CPR card. Upon receipt of your card, please make a photo copy of the card and submit the copy to the Nursing Office. Class schedules are available online at the American Heart Association website, [www.americanheart.org](http://www.americanheart.org) and the American Red Cross website, [www.redcross.org](http://www.redcross.org).

Students who are unable to meet the performance criteria for Certification due to health restrictions must:

1. present a physician’s statement excluding them from this requirement and
2. attend the theory component of the CPR course.

Proof of exemption must be sent directly to the Nursing Dept. office, Room B-302, from the physician; attendance at the course must be validated.
This order form, along with your payment must be received by M&M Medical Sales, Inc. by July 28, 2014. Orders received after this time will not be guaranteed for pick up at the designated time.

Due to FDA regulations, once you receive your Nurse Skills Kit, it cannot be returned. The contents of this Kit have been developed in conjunction with your instructors and are required for your program.

Payment is accepted by Cash, Certified check, or Money Order only.

All orders must be mailed to:

M&M Medical Sales, Inc.
356 Maple Avenue
Glen Rock, New Jersey 07452

by July 14, 2014

Please include the following information:

Student's Name:________________________________________________________

Telephone Number: ________________________________________________

PLEASE RETURN THE ENTIRE ORDER FORM

The Nurse Skills Kit is a custom package, which will be made to order for you. If you do not order before the deadline, M&M Medical Sales cannot guarantee the availability of a Nurse Skills Kit for you.
Dear Level One Student:

Welcome to the Nursing Program at Bergen Community College. We have a proud 40+ year history of educating nurses to provide health care to area residents and beyond. The faculty and nursing administration rigorously and regularly reviews student and program outcomes always seeking new ways to improve the teaching/learning process. As a result of our studies, we are so pleased to introduce a program to further aid nursing students to learn the theory and clinical application of theory to nursing practice.

This program is an extension of our long affiliation with ELSEVIER/EVOLVE REACH testing and remediation. You may recognize the name because the entrance examination you took to qualify for the Nursing Program is an EVOLVE product. The program, utilized by numerous nursing programs throughout the country, will include the following products:

- Practice Tests and Case Studies
- Patient Reviews
- Assessment examinations to be offered at the end of each course

This program will provide YOU with personalized electronic remediation content; it will help you address your weaknesses. Your performance will be assessed in accordance with the categories tested on the HESI exit examination AND the national licensing examination, (NCLEX-RN) that you will be required to take to become a registered nurse.

We wish you the very best and will share in your success as you achieve your goal of becoming a registered nurse.

*Dawn Kozlowski PhD, RN, CNE
Associate Dean of Nursing*
HOW TO ENROLL IN THE ELSEVIER/EVOLVE REACH PROGRAM

You may **pick up your ACCESS KEY CODE on**

**Wednesday, June 25, 2014 at Nursing Orientation**

**9:00 a.m. in Room TEC-128**

Your online Evolve registration must be completed as directed on the form you receive by **July 14, 2014 – no exceptions.**
NURSING STUDENT SCHOLARSHIPS

There are many scholarships available for students enrolled in the Nursing Program at Bergen Community College. We encourage all students to take advantage of the financial assistance offered by the scholarships available at BCC.

Nursing student scholarships and the application can be viewed on the Bergen Community College web page via the following link:

http://www.bergen.edu/scholarships
BERGEN COMMUNITY NURSING PROGRAM

Mr.    Mrs.
FULL NAME:   Ms.    Miss: ________________________ PHONE #:: ________________________

ADDRESS: ________________________________________________________________

CITY: ____________________  STATE:_____________ ZIP:______________ APT#________________

PANTSUIT w/ emblem sz ______  (   ) @ $54.00 ea. $ ____________
NAME PIN sz ______  (   ) @ $ 7.00 ea. $ ____________
BANDAGE SCISSORS (   ) @ $ 5.00 ea. $ ____________
WARM-UP JACKET w/ emblem sz ______  (   ) @ $23.00 ea. $ ____________
MENS TUNIC w/ emblem sz ______  (   ) @ $25.00 ea. $ ____________
MENS SLAX sz ______  (   ) @ $21.00 ea. $ ____________
MENS WARMUP JACKET sz_______ (    ) @$26.00 ea. $ ____________

* MINIMUM 2 GARMENTS IN ANY COMBINATION *
WARM-UP JACKET OPTIONAL

OTHER ITEMS AVAILABLE
SHOES style ______ sz ______ (   ) @ $          ea. $ ____________
STETHOSCOPE KIT color ______ (   ) @ $30.00 ea. $ ____________
WATCHES (   ) @ $          ea. $ ____________

Shipping Charge $ 9.50

CASH * MONEY ORDER * CREDIT CARD
* PAYMENT AT TIME OF FITTING *
AMOUNT PAID $ ____________
BALANCE $ ____________

FITTING HOURS: Monday thru Saturday 10:00a.m. to 5:00p.m. NO APPOINTMENT NEEDED

PANTSUIT: tunic size ________________
slax size ________________
alter tunic ____________________
alter slax ____________________
Textbooks
Fall 2014 and Spring 2015

NUR 181 - Assessment


Or


NUR 182 - Pharmacology / Math


NUR 183 – Concepts

or


Optional


Nursing Care Plan Books - student choice

