BRISTOL-PLYMOUTH REGIONAL TECHNICAL SCHOOL
PRACTICAL NURSE PROGRAM
207 Hart Street, Taunton, MA 02780

Health Clearance Form

DOCUMENTATION ON THIS FORM IS REQUIRED. ALTERNATIVE DOCUMENTATION WILL NOT BE ACCEPTED.

Name of PN Student: _____ Date of Birth: _____

Dear Health Care Provider:

For the protection of students, patients, faculty and others, nursing students must provide documentation that they can fully participate in the program of study. This includes being able to meet the demands of mentally, physically, and emotionally providing bedside patient care in simulated and clinical settings.

The MA Board of Registration in Nursing regulations 244 CMR 9.00 states: *Impaired means the inability to practice nursing with reasonable judgment, skill and safety by reason of alcohol or drug abuse, use of other substances, a physical or mental illness or condition, or by any combination of the foregoing.*

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

This is to verify that the above named student, was examined by me on _____and found to be:

_____ Well student with no conditions/impairments identified that would limit this student's ability to fully participate in all activities of the Practical Nurse Program.

_____ Conditions/impairments have been identified that would prohibit this student's ability to fully participate in the activities of the Practical Nurse Program.

Please identify any conditions or limitations that would/may affect this student's ability to fully participate in the Practical Nurse Program:

By signing below, I, the Health Care Provider, verify the above documentation.

Signature of Health Care Provider:	
Date:	
Printed Name:	
Address:	
City/Town, State:	
Telephone:	

All student information is confidential.

6/2018, 9/2019, 6/2022, 9/2022