

Dear Physical/Occupational Therapy Student,

I want to congratulate you on your acceptance into the **DPT** program at Idaho State University as a member of the class of 2012. For the next three years you will be actively involved in both didactic and clinical experiences as you begin training for your career in **physical or occupational** therapy. An essential component of this training will involve clinical practice experiences on and off campus in various hospitals, nursing homes, private practices and other health care agencies. To ensure the safety of you as a student and the patients with whom you will be in contact, immunizations and certifications are required by the agencies as part of the legal agreements established for the purpose of student practice and education. Further, some clinical sites also mandate drug screens and criminal background checks prior to clinical participation in their facilities.

In the effort to make sure that all students matriculating in the degree program are compliant with these policies and procedures, the university is asking that you completed the immunizations and be aware of other needed certifications as outlined on the attached form. The form should be completed and documentation attached as described and then sent directly to the Department **of Physical and Occupational Therapy, Mail stop 8045, Idaho State University, Pocatello, Idaho 83201**. The form must be completed and sent prior to **August 20, of 2009**. **Failure to do this will not allow you to matriculate into the program.** Please contact the DPOT office at 208-282-4095 if you have specific questions.

With best wishes,

Alexander Urfer, PT, PhD
Chairperson and Professor of Physical Therapy

Department of Physical and Occupational Therapy Immunization and Certification Checklist

Name _____ SS# _____

Program (circle one) DPT MOT

Facility that did the procedure should provide their official stamp and date(s) of the procedure, or you should attach documentation for each procedure

<u>Required Immunizations:</u>	<u>Date</u>	<u>Documentation/ Facility Stamp</u>
<u>Varicella (chickenpox):</u> documentation of 2 vaccine doses or proof of a titer. History of the disease does not meet this requirement.	_____	_____
<u>Measles, Mumps & Rubella/Rubeola (MMR):</u> proof of 2 vaccine doses	_____	_____
<u>Tuberculosis:</u> annual screening for the past two years or proof of a PPD test done within the last year	_____	_____
<u>Hepatitis B:</u> series of three vaccinations or signed waiver	_____	_____
<u>DPT/Td (Tetanus/Pertusis/Diphtheria):</u> series of 3 vaccine doses. One dose must be within the last 10 years.	_____	_____
<u>Polio:</u> vaccine series of 3 doses	_____	_____

1. **A criminal background check**
 - a. **Conviction of a felony or other serious offense will likely result in denial of placement for the clinical assignment, and consequently affect your standing in the program. If you have any questions about whether your criminal history, if any, will prevent or restrict your ability to obtain a license in this field, you should discuss this with the appropriate licensing agency or board.**
 - b. **This can be done at any Law Enforcement Office or at Campus Security Offices.**

2. **A CPR Certification - Certification must include adult, child, and infant**

NOTE: If needed, other tests may be required dependent on clinical affiliation circumstances.

Student Signature _____

For office use only:

Date received: _____

Approved by: _____