PROGRAM NAME & ADDRESS:

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SUBJECT: Letter of Good Standing for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s full legal name**

This letter is to certify that the Graduate student listed above is in good standing with our institution. They have met the following requirements as delineated in our Affiliation Agreement with CHRISTUS Santa Rosa Health System and/or CHRISTUS Children’s.

□ Professional liability insurance coverage

□ Mandatory health insurance coverage

□ Successfully passed federal and state criminal background checks

□ Completed training in infection control practices, universal precautions, fire and safety

□ Maintains current CPR certification

□ Completed HIPAA Privacy training

□ And up to date with the following immunizations or have provided proof of immunity:

* Tetanus-Diphtheria
* Hepatitis B series
* Measles, Mumps, & Rubella (MMR)
* Varicella
* Tuberculosis screening-annually
* Influenza

The student has been designated to perform their respective clinical rotation hours:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Full name and department of preceptor**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dates of clinical rotation**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Clinical Program Director Signature,** **Date**

**or Designated Signatory**

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**Printed Name and Title**