

Dear Applicant,

Thank you for your interest in the WOCN-accredited, Wound Care Education Program at the MUSC College of Nursing. The program offers two options: a traditional, onsite, 3-week course that includes all the didactic and clinical experiences onsite in Charleston and a 4-month, Split-Option, Web-Enhanced, Distance Learning Course that requires the initial first week on-site in Charleston with the balance of the course completed off-site using computer-based learning activities. Applicants must have a Baccalaureate Degree or higher and hold a current RN license in their state of practice and to participate in the onsite program with clinical experiences in SC, RNs must have a current license from SC or another Compact State.

To participate in the Split-Option, Distance Learning Course, the nurse must be proficient in computer skills. Participants in the distance course have the option to arrange clinical experiences (after completion of all didactic) off-site or return to Charleston. If distance course participants wish to have off-site clinical experiences, they must be able to arrange 40 hours of clinical experiences with fully qualified, WOCN certified nurse preceptors who (along with their employer) will agree to enter into a clinical affiliation agreement with MUSC. RNs who attend the distance course must be duly licensed and hold a license in the state in which they plan to take their clinical experience.

To meet clinical placement requirements, nurses must provide evidence of a recent 9-panel drug screen and a Level I criminal background check (within 3 months of application), which can be obtained from CertifiedBackground.com at the expense of the participant. The procedure to contact CertifiedBackground.com is included in the application packet. **Should the drug screen or criminal background check reveal an adverse event that would prohibit clinical placement, participants will not be eligible for admission to the program.** In addition, to obtain MUSC identification badges and arrange library privileges with online access during the course, MUSC Human Resources processes a criminal record search to verify suitability of participants to be sponsored and receive an MUSC Net ID account (MNA accounts). Students are required to sign and return the enclosed release forms (Non-Paid Personnel Application for Net ID Account and Applicant Information Release Form) to process this search.

The course is a very intensive program to prepare the nurse for practice as a Wound Care Specialist. The course is comprised of at least 60 hours of didactic instruction and 40 hours of clinical instruction. Clinical instruction is provided by WOCN certified nurse preceptors in hospitals, home health, outpatient clinics, and other settings. Completion of the course requires satisfactory performance on each of the following activities: 2 written, 100-question, multiple-choice examinations; a written role implementation plan, development of a written teaching plan and verbal presentation of a class relevant to wound management, written critique of a research study for evidence-based care, and satisfactory performance in the clinical experiences. **Once candidates are accepted, they are mailed a packet containing information about the reading assignments and projects so they can prepare in advance for the course.**

A certificate of completion and continuing nursing education contact hours are awarded upon satisfactory completion of all course requirements. Graduates of the WOCN-accredited Wound Care Specialty Course are eligible to take the national wound care nurse certification examination offered by the Wound, Ostomy Continence Nursing Certification Board

(WOCNCB). The Wound Care Specialty Course has been accredited by the Wound, Ostomy and Continence Nurses Society (WOCN) since 1994 and was granted full accreditation in 2007 for five years. The course is designed according to WOCN criteria.

Enclosed you will find the application packet along with a housing list. Please refer to the brochure or website regarding tuition, fees, and course dates. Complete the enclosed application as directed and return the required, non-refundable application fee of \$100.00 with the completed packet. We look forward to hearing from you. If you have any questions about the requirements or course content, please call me at (843) 792-4630 or 2651 or Email me at: bonhamp@musc.edu.

Sincerely,

Phyllis Bonham, PhD, RN, MSN, CWOCN
Associate Professor
Director, Wound Care Education Program

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA**

Application for Admission to Wound Care Specialty Course

The admissions procedure requires you, as the applicant, to gather individual letters of recommendation and transcripts and to submit a complete set of documents with your application. The advantage of this system is that you know the application is complete when it is submitted and you are able to exercise personal control over timely completion. Carefully read through the instructions and relevant information before completing any application materials. All questions should be answered carefully and completely. Please print or type your answers. **DO NOT MAIL** your application packet until you are able to enclose all required materials (exceptions can be made with permission of the Program Director). We recommend that you make copies of all application materials (except confidential reference forms) for your own records. **All application materials become the property of the Wound Care Education Program at the Medical University of SC and cannot be returned or forwarded to other institutions.**

This application packet contains:

- Minimum abilities for participation
- Refund policies
- Application for Wound Care Specialty Course
- Drug Screen/Criminal Background Check: CertifiedBackground.com Student Instructions
- MUSC Non-Paid Personnel Application for Net ID Account and Applicant Information Release Forms
- Confidential appraisal form (blank form may be duplicated for use)
- Transcript request form (blank may be duplicated for use)
- Forms for Immunizations, proof of universal/standard precautions, OSHA training for Infectious Diseases/Blood Borne Pathogens, and HIPAA training form
- Hospitalization insurance information form
- Report of physical exam form
- **Addenda I-V (ONLY for Split-Option, Web-enhanced, Distance Learning applicants)**

Mail the completed application and required forms and documentation to:

Phyllis Bonham, PhD, RN, MSN, CWOCN
Director, Wound Care Education Program
College of Nursing, Medical University of South Carolina
99 Jonathan Lucas Street
MSC 160
Charleston, SC 29425

***Application Deadline: Early application is encouraged. Class size is limited and participants are accepted on a first-come basis until the class is full.**

- **On-site Course: 6-8 weeks prior to course**
- **Split-option, Web-enhanced, Distance Learning Course: 8-10 weeks prior to course**

Application Instructions

1. Complete the application for admission, providing complete and accurate information. Submit copies of current RN license, professional liability insurance, and current CPR certificate.
2. Contact CertifiedBackground.com to obtain the 9- panel drug screen/Level I background check and enclose those reports.
3. Sign the MUSC release of information forms (for NET ID accounts and background search)
4. Submit an official transcript from each college attended for ADN, BS, MS degree or higher.
 - Send a transcript request to each college/institution attended. The registrar should seal the envelope, sign across the seal, and return the official transcript to you. Include this envelope, with the seal unbroken and the registrar's signature intact, with your application.
 - You may photocopy the Transcript Request form in the application packet. *If your college will not give you an official transcript, insert their explanation and their intention to send the documents directly to the Wound Care Education Program.*
5. Three letters of reference/recommendation. You may photocopy the blank reference form. You are responsible for securing confidential appraisals from your employer and individuals who have known you at least one year and are qualified to write about your potential for success as a wound care nurse. **One reference must be from your current employer verifying current employment.**
7. ****NOTE:** Applicants for the Split-option, Web-enhanced, Distance Learning course must also complete Addenda I-V enclosed at the end of the application.
8. **Enclose the NON-REFUNDABLE application fee of \$100.00. A check or money order drawn on a U.S. bank, payable to MUSC-College of Nursing must be returned with the application packet. No application will be considered until the fee has been received.**
9. COMPLETED application materials should be mailed all together in one envelope. Please check the items listed below to ensure that you have included all of the required documents:
 - __ Application, complete and signed
 - __ Copy of current SC RN license or license from a Compact State (onsite program) and current RN license if not from SC
 - __ Copy of current CPR certificate
 - __ Copy of professional liability insurance (\$1: 6 Million minimum)
 - __ Copy of health insurance card for Medical-Hospital Insurance information
 - __ 9-Panel drug screen and criminal background check results from CertifiedBackground.com
 - __ MUSC Non-paid Personnel Application for NET ID Accounts and MUSC Information Release
 - __ 3 confidential appraisal forms (***at least one from current employer***)
 - __ Official transcripts from College/Institutions attended
 - __ Report of recent physical examination signed by physician (within 3 months of application)
 - __ Evidence of immunizations/titers: Current TB (within 3 months), Tetanus, Rubella, Rubeolla, Hepatitis vaccine and titer, and 2 Varicella vaccines or titer
 - __ Evidence of current Universal/Standard Precautions Classes for infectious diseases control, blood borne pathogens (i.e. OSHA Training)
 - __ Completion certificate from MUSC online OSHA training
 - __ Evidence of current HIPAA training
 - __ Copy of Photo Identification or copy driver's license with photo
 - __ ****Addenda I-V for Split Option, Distance learning applicants only**
 - __ **\$100.00 application fee (NON-REFUNDABLE)**

University Minimum Abilities for Eligibility to Participate Successfully in Education Programs and Activities

The Medical University of South Carolina does not discriminate on the basis of race, creed, national origin, sex, age or disability in the recruitment and admission of students, employment of faculty and staff, and the operation of other educational activities and programs as specified by federal laws and regulations.

While admission decisions do not take disabilities into consideration, nor are applicants invited to disclose a disability, all persons interested in entering a health profession education program should be aware of minimum abilities required for success. Participants must be capable of successfully completing each required clinical rotation. These abilities are needed by all students in the university:

- Ability to learn, think critically, analyze, solve problems, and reach judgments: Make proper assessments, obtain and interpret data, prioritize, identify safe alternatives, perform arithmetic functions (addition, subtraction, division, ratios, and simple algebra).
- Ability to perform interventions, duties, and tasks requiring manual dexterity (gross and fine movements) use sterile techniques and universal precautions, operate and maintain equipment, and obtain samples/specimens.
- Ability to perform tasks requiring physical strength: to support, position, transfer/ambulate patients with walker, cane, or crutches; sit/stand/walk for extended periods of time; perform CPR/resuscitation, lift at least 50 pounds, reach 18 inches above head, push 200 pounds independently; and stoop/bend without limitations.
- Ability to adapt to a variety of patient/client situations, including crises/emergencies.
- Ability to maneuver in small spaces and from room to room.
- Ability to communicate orally and in writing with accuracy, clarity, and efficiency to establish rapport with patients, families, and peers: Read, write, speak, and comprehend English with sufficient skill to communicate effectively verbally and non-verbally, and write or document legibly.
- Ability to initiate health teaching and explain treatment procedures.
- Ability to see, hear and touch, smell, and distinguish colors.
- Ability to measure outcomes of patient care, psychological status, and use monitoring devices to measure: body weight, vital signs, and intake/output.
- Ability to participate in discussion in the classroom, clinical area, and with colleagues/patient/clients, and the public.
- Ability to acquire information developed through classroom instruction, clinical experiences, independent learning, and consultation.
- Ability to complete reading assignments and to search and evaluate literature.
- Ability to complete written assignments and maintain written records.
- Ability to meet deadlines, to manage time.
- Ability to complete computer-based assignments and use computer for searching, recording, storing, and retrieving information.
- Ability to accept responsibility and accountability, able to perform duties under stress (emotional stability), function as part of a team, and participate in role-playing activities.
- Ability for self-perception and awareness, assertive, and able to delegate.

These abilities may be accomplished through direct student response, through use of prosthetic devices or through personal assistance (e.g., readers, signers, note takers, etc.) The responsibility for the purchase of prosthetic devices serving a student in meeting the required abilities remains with the student and/or the agency supporting the student.

Upon admission, a student who discloses a disability (with certification) is assured of reasonable accommodation. These accommodations include individual counseling, extended test taking time, and other reasonable enabling services that can be provided within the budgetary and personnel constraints of the Wound Care Education Program as determined by the Program Director, who has final discretion in determining a student's suitability to attend the course. Students seeking accommodation must initiate their request in writing to the Program Director at the time of initial application. A personal interview will be conducted as indicated by the Program Director.

Refunds

Application fee: The application fee is non-refundable under any circumstances.

Tuition: If the applicant submits a written notice of cancellation/withdrawal to the Program Director, 3 weeks in advance of the first day of the course, tuition fees that have been paid (except the non-refundable application fee) are refundable minus a processing fee of \$200.00. In the event life/health emergencies (with appropriate documentation) do not permit 3 weeks advance notification of the Program Director, tuition may be refunded at the discretion of the Program Director, minus a \$200.00 processing fee. No refunds are provided after the first day of the course.

Student Withdrawal

A student who withdraws or is unable to attend a scheduled course with three weeks notice may be eligible for admission to the next available course on a space available basis at the sole discretion of the Program Director based on a review of the circumstances of the withdrawal.

Cancellation of the Course

The Wound Care Education Program will not provide a refund should a course begin only to be interrupted by an act of God, an act of war or an act beyond its control. In such instances, coursework will be rescheduled to allow completion by registered participants. A refund of paid tuition will be made if the Wound Care Education Program cancels a course in advance for any reason under its control. If an on-going course is interrupted and unable to be completed or rescheduled due to unforeseen/uncontrollable circumstances, the tuition fee will be refunded on a pro-rated basis:

- During First Week, 50% refund
- During Second Week, 25% refund
- During third week, *No refund.*

No refund is made for any housing or travel expenses incurred by the participant under any circumstances of cancellation of the course.

Charleston, SC: Housing Options

Note: This list is compiled and provided only for the information and convenience of wound course participants. The University, College of Nursing, or Wound Care Education Program do not screen, endorse, or assume any responsibility for the facilities listed. It is up to the individual seeking housing to make arrangements and determine if facilities are satisfactory to meet their needs. (** Within walking distance to campus according to your walking habits)

Hotels

Charleston Marriott Hotel**	843-723-3000
Charming Inns Inc.	843-722-8680
Comfort Inn** (Inquire at Hotel if special MUSC rate available)	843-577-2224
Courtyard by Marriott	843-722-7229
Embassy Suites-Charleston	843-723-6900
Embassy Suites-North Charleston (www.embassysuitscharleston.com)	843-747-1882
Extended Stay Hotel	843-744-7590
Hampton Inn Hotel Riverview	843-566-5200
Hawthorne Suites Hotel	843-577-2644 (800-526-1133)
Hilton (Mt. Pleasant)	843-856-0028
Holiday Inn- Riverview (Charleston)	843-566-7100
Holiday Inn (Mt. Pleasant)	843-884-6000
Mainstay Suites (Mt. Pleasant)	843-881-1722 (800-660-MAIN)
Sleep Inn (Mt. Pleasant)	843-856-5000 (800-Sleep-Inn)
Studio Plus and Extended Stay Hotel	843-553-0036 (800-646-8000)

Bed and Breakfast

Cannonboro Inn and Ashley Inn**	843-723-8572
Historic Charleston Bed & Breakfast	843-722-6606

Off-Campus Housing Office (MUSC)	843-792-0394
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Private Homes-Rental Rooms: Please discuss any issues you have with the private homeowners regarding fees, arrangements, tobacco use, presence of pets in their homes, or special needs.

- Beth Griffin** 843-722-3303
- Marie Ferrara** 843-722-2505
- Terri Herbert Wk: 843-792-1370
H: 843-762-2002
- Martha Sparwasser 843-884-1582
- Marion Sullivan 843-881-6994
(msullivanandco@aol.com)
- Angela Williams H: 843-881-1829
Wk: 843-953-5378

Charleston Chamber of Commerce Main Office	843-577-2510
Charleston Visitor/Convention Bureau	843-853-8000/1-800-868-8118

- **Download and complete the Multi-State Licensure Privilege Notification Form, send it to the SC Board, keep a copy for yourself, and attach a copy of the form to this application.**
- **If you are not licensed in SC or a Compact State, you must apply for a SC license by endorsement. "License by Endorsement Application" can also found at: www.llr.state.sc.us.**
- Bring your RN license (s) for visual verification on the first day of course

B. Professional Liability Insurance: ***You must submit a certificate of insurance in your name verifying your individual coverage in the minimum amounts of \$1 million incident and \$6 million per annual aggregate.***

Insurance Agency: _____
 Address: _____ Policy #: _____
 Date Effective _____ Date Expiration _____ Limits of Liability: _____

C. CPR Certification Date: _____ **(Attach copy of current CPR certification)**

D. Annual Universal/Standard Precautions Class (within current year): Infectious Diseases Control & Blood Borne Pathogens (OSHA Training): Date _____
(Submit evidence of class attendance)

E. **Complete MUSC's OSHA requirement.** Go to the link for MUSC's online OSHA and complete the 4 components for: blood borne pathogen, fire and life safety, hazards communications, and personal protective equipment. Go to: <http://www.carc.musc.edu/training/modules/osha/>. Click on the link titled "Register Here" in the middle of the page to register for the program using your social security number. Once you finish the OSHA module, print out the certificate of completion and include a copy of the certificate of completion with this application. **Date of Completion** _____.

F. Date of HIPAA training: _____ **(Provide evidence of HIPAA training).**

G. Provide evidence of picture identification (picture ID or driver's license with picture will suffice)

H. Have you ever been convicted of any crimes or misdemeanors other than minor traffic violations? Yes _____ No _____ If yes, Explain:

I. **9-panel drug screen/Level I criminal background check: See attached instruction form to obtain drug screen and background check. Attach copy of drug screen & background check results from Certified Background.com (within 3 months of the application).**

V. SIGNATURE:

I hereby certify that the information in this application is correct. I understand that any misrepresentation or omission of facts called for in this application is cause for cancellation of the application or expulsion from the program.

Signature

Date

CERTIFIEDBACKGROUND.COM
WOUND COURSE PARTICIPANT INSTRUCTIONS

Background Check Required

To meet requirements for clinical affiliation placement, the Wound Care Education Program at Medical University of South Carolina requires that each participant provide evidence of **BOTH a recent 9-panel drug screen test and Level I criminal background check as part of the application process obtained from CertifiedBackground.com.**

About CertifiedBackground.com

CertifiedBackground.com is a background check service that allows participants to order and purchase their own 9-panel drug test and background check online. The results of the 9-panel drug test and background check are posted to the CertifiedBackground.com website in a secure, tamper-proof environment, where the participant as well as MUSC (Wound Care Program Director) can view results. **To order your 9-panel drug test and background check from CertifiedBackground.com, please follow the instructions below.**

Ordering Instructions:

1. Go to www.CertifiedBackground.com and click on "Students"
2. Package Code box, enter the MUSC's code for the tests you need which are:
ed13bd --for background check and 9-panel drug test
3. Select a method of payment: Visa, MasterCard, or money order
4. **Call to obtain required chain of custody forms for the 9-panel drug screen:**
After you submit your information on the website, **CALL** and /or **EMAIL** Sandy Ison (888-723-4263, Ext 7134; spison@castlebranch.com) and leave your NAME and ADDRESS so that they can mail your drug testing paperwork including the Chain of Custody Forms.

Viewing Results

Once your order is submitted, you will receive a password to view your results. When your results are complete, you can view and print a copy at CertifiedBackground.com by entering your password, then the last 4 digits of your Social Security Number. If you wish to share your results with your Administrator or another individual, provide them with a copy of your password and the same instructions you followed. **It is the Participant's responsibility to submit a copy of the 9-panel drug screen and criminal background check results with the completed application materials to the MUSC Wound Care Education Program.**

For questions, about CertifiedBackground.com

www.Certifiedbackground.com

Phone: 888-666-7788

info@certifiedbackground.com



**MUSC Non Paid Personnel Application
NET Identification Accounts (MNA)**

Date of Application: _____

1. Name: _____

Date of birth: _____ Social Security: _____

2. Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____

3. Phone Number: _____ Email: _____

4. Current/Most Recent Occupation: _____

5. Current/Most Recent Employer: _____

6. What is your approximate length of commitment?
(Enter dates of the wound course you will attend) _____

7. Do you have any relatives who are currently employed at MUSC? Yes _____ No _____
If "Yes", give name, relationship and department _____

8. Have you ever been convicted of any crime other than a traffic violation?
Yes _____ No _____ If "Yes", explain _____

9. Disabilities or special needs: _____

10. I understand that the Medical University of South Carolina reserves the right to accept or reject my application in its sole discretion and that the above statements made in this application are true.

11. I AUTHORIZE THE MEDICAL UNIVERSITY OF SOUTH CAROLINA TO CONDUCT A CRIMINAL RECORD SEARCH TO VERIFY MY SUITABILITY TO BE SPONSORED AND RECEIVE A NET ID ACCOUNT.

I release MUSC University from implied liability.

Signature: _____ Date: _____



**MEDICAL UNIVERSITY OF SOUTH CAROLINA
WOUND COURSE APPLICANT INFORMATION RELEASE**

AUTHORITY AND CONSENT TO RELEASE/OBTAIN BACKGROUND INFORMATION

Must be fully completed and signed

The information received by the Department of Human Resources Management as a result of signing this Release may be used to assist in a background investigation of you and may be used in conjunction with your application to evaluate your suitability to participate in the Wound Care Education Program (WCEP) at the Medical University of South Carolina.

I hereby authorize the release to the Medical University of South Carolina of information held by any parties regarding previous employment, my criminal history record, and/or record of convictions in state and local files for violation of any federal, state, local statutes or ordinances, military records, my credit history, workers compensation history, driving record, and scholastic/educational records and hereby release said persons, schools, companies, government agencies, court and law enforcement authorities from damage whatsoever for reusing this information.

I hereby acknowledge that the Medical University of South Carolina cannot vouch for or guarantee the accuracy of information provided by third parties. Accordingly, I release the Medical University of South Carolina and its agents from any and all liability arising out of any errors or omissions regarding my background information. Any information obtained by the Medical University of South Carolina independently or through a Consumer Reporting Agency shall remain confidential and no further disclosure to other parties shall result. The information obtained as a result of the investigation shall be used exclusively for the purpose of admission to the Wound Care Education Program.

Any misrepresentation, falsification or misleading statements or omission of facts by me may result in my being disqualified from further consideration for admission to the Wound Care Education Program or in my immediate termination should I already be enrolled in an education program at the Medical University of South Carolina.

Applicant Information

This permission is given this _____ day of _____, year _____
Date Month Year

Name of Applicant

Social Security Number

Street Address

Date of Birth

City State Zip

Driver's License Number State

Signature of Applicant

* Age is not a criterion in any decision, but is used for identification purposes ONLY

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA
99 JONATHAN LUCAS STREET
MSC 160
CHARLESTON, SC 29425**

CONFIDENTIAL REFERENCE FORM

APPLICANT

I _____, am applying for admission to the Wound Care Specialty Course College of Nursing, MUSC. I am aware of the provisions of the Family Education Rights and Privacy Act. I hereby authorize the release of the requested information directly to the Medical University of South Carolina. I realize that I will not view nor be informed of any portion of your reply. I desire that an objective evaluation be rendered.

Signature _____ Date _____

PART I: APPRAISOR

A frank statement of your opinion will assist us in determining the applicant's desirability as a wound care nurse. Please bear in mind that the health professions entail grave responsibilities and, therefore, a high rating should be given only to the really superior applicant. Place a checkmark in the appropriate column to rate the applicant on the following attributes:

	Superior	Very Good	Fair	Poor	Unknown
Personality	_____	_____	_____	_____	_____
Maturity	_____	_____	_____	_____	_____
Perseverance	_____	_____	_____	_____	_____
Reality	_____	_____	_____	_____	_____
Initiative/Creativity	_____	_____	_____	_____	_____
Intellectual Ability	_____	_____	_____	_____	_____
Potential Leadership	_____	_____	_____	_____	_____
Communication Skills	_____	_____	_____	_____	_____

PART II: APPRAISOR

Considering this applicant's general qualifications for the health professions, please rate him/her as:

____ Very desirable ____ Desirable ____ Fairly desirable ____ Undesirable

How long have you known the applicant? From _____ to _____

In what capacity have you know the applicant?

Current Employer____, Supervisor ____, Major Advisor ____, Clinical Teacher ____, Other____

Additional remarks would be appreciated. Please use reverse side for further comments. _____

Signature_____ Date_____

Name and Position (printed or typed)_____

Address_____

Phone: _____ Fax_____

Email: _____

Please attach any other evaluative documents to this appraisal, place in a sealed envelope, sign across the seal, and return to the applicant.

The Medical University does not discriminate on the basis of race, creed, national origin, sex, age, or disability in the recruitment and admission of students, employment of faculty and staff, and the operation of other educational activities and programs as specified by federal laws and regulation.

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TRANSCRIPT REQUEST

APPLICANT

Name _____ SSN _____
 Last First Middle

Current Address _____
 Street City State Zip

School _____

Dates of Enrollment _____ Degree and Year _____

I authorize the release of a transcript of my academic record to the Wound Care Education Program of the College of Nursing at the Medical University of South Carolina _____

Signature

Date

REGISTRAR:

Please enclose this form along with one copy of the applicant's transcript in an official university envelope addressed to the applicant. Seal the envelope, date, sign, stamp, or place your seal on the back flap. **Return transcript to the applicant.**

Be sure to include instructions on how to interpret the transcript and an explanation of your grading system. If the transcript is not in English, include an English translation. If a copy of the student's academic record cannot be forwarded, please indicate the reasons. If your policy does not allow returning the sealed envelope to the candidate, please send the document directly to the Wound Care Education Program at the address listed above and notify the applicant that you have done so.

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COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA
99 JONATHAN LUCAS STREET
MSC 160
CHARLESTON, SC 29425**

Health Requirements

ALL STUDENTS ENTERING MUSC, FULL TIME AND PART TIME, MUST PROVIDE PROOF OF IMMUNIZATIONS AND ARE REQUIRED TO HAVE HOSPITALIZATION INSURANCE IN THE EVENT OF ILLNESS OR INJURY. STUDENTS NOT MEETING THESE REQUIREMENTS WILL NOT BE ALLOWED TO REGISTER.

1. Immunizations must be completed and signed by a physician, nurse, or Health Department and documented in English.
2. A physical examination is required within 3 months prior to application.
3. Students are required to have proof of immunity and/or immunization to the following prior to matriculation:
 - a. RUBEOLA (Red Measles) requirements are based on date of birth:
 - Persons born on or after 01/01/57 are required to have 2 Live Red Measles vaccines on or after the age of 12 months AND both after 12/31/67 OR positive Rubeola Antibody Titer (blood test).
 - Persons born on or before 12/31/56 are required to have 1 Live Red Measles Vaccine after 12/31/67 OR positive Rubeola Antibody titer (blood test)
 - b. RUBELLA (German Measles). One live vaccine **or** positive Rubella Antibody Titer (blood test).
 - c. TETANUS. Must have had a booster within the past 10 years. If your last Tetanus booster was before 5/1/97, a Tetanus/Diphtheria/Pertussis (Tdap) Vaccine (available 9/2005) is recommended. A Tetanus Toxoid (TT) alone is not acceptable.
 - d. INTRADERMAL PPD (Mantoux 5 TU). TB required within 3 months of application and results documented in "mm". Tine test is not acceptable. An intermediate result (1-9 mm induration) requires that a 2nd PPD be done 1 week after the 1st PPD (placed on the opposite arm). If test results are ≥ 10 mm or if history of previously positive TB skin test, a Chest X-ray performed after skin test was documented positive is required and must submit copy of X- ray.
 - e. Varicella (chicken pox.): Must provide proof of immunity through 2 Varicella Vaccines (Varivax), or a Positive Varicella IgG Antibody Titer (blood test).
 - f. Evidence of Hepatitis B Vaccines (3) AND a Hepatitis B surface Antibody Titer (**copy of lab report**) of Immunity is Mandatory for students enrolled in the Wound Care Education Program. If Hepatitis B surface Antibody is negative, CDC recommends an entire 2nd Hepatitis B Vaccine series and after the 2nd series, a titer is repeated in 1-2 mos. If the HBsAB is negative after re-

vaccination, retest for Hepatitis B surface Antigen (HBsAg) to assess if chronically infected with Hepatitis B.

TO BE COMPLETED BY ALL STUDENTS:

1. Immunization Form, Medical-Hospitalization Insurance Information Form
2. Report of Physical Exam Form

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**IMMUNIZATION/ MEDICAL HOSPITALIZATION INSURANCE
INFORMATION**

The following data is required on each student. This information must be submitted for admission into the Wound Care Specialty Course. Documentation must be provided as evidence of the following:

Name of Student: _____

1. PPD.

- **Date Planted** _____ **Planted by (signature/credential)** _____
- **Date TB test Read** _____ ***Reaction size in mm** _____
- **TB test read by (signature/credential)** _____
- **NOTE: If TB test is positive (≥ 10 mm), a chest X-ray and statement of evaluation by a physician is required.**
 - When was the last chest x-ray? Date _____ Results _____
 - Date evaluated by MD _____ Signature MD _____
 - Was there prophylaxis? Yes (specify) _____ No _____
- **Submit evidence of date TB planted, date read/ results/ signature & credentials of individual planting and reading test. Submit evidence of X-ray only if positive TB test.**

2. German and Red Measles.

- (Red Measles) Rubeola vaccine Date #1 _____ Date #2 _____ **or**
 - **Proof of titer** _____ Date _____
 - **Submit evidence of vaccinations or positive titer for Rubeola**
- (German Measles) Rubella vaccine Date _____ **or**
 - **Proof of titer** _____ Date _____
- **Submit evidence of vaccinations or positive titer for Rubella**

3. Varicella (Chicken Pox). Positive Varicella IgG Titer (blood test of immunity) required or two varicella (Varivax) vaccines.

- Varicella Vaccines (Varivax):
 - Date Vaccine #1 _____ Date Vaccine # 2 _____
- **OR**
 - Date Positive blood titer _____
- **Submit evidence of vaccines/ or evidence of titer of immunity.**

4. **Hepatitis B.**

- I have completed the (3) hepatitis B vaccine series: Yes _____ No _____
- Dates Hepatitis B Immunizations: #1 _____, #2 _____, #3 _____
- Titer Date _____
- **Submit evidence of immunizations and Titer results of immunity.**

5. **Tetanus (within 10 years).**

- Date of last booster _____. **Note if before 5/1/97, Tdap (Tetanus/Diphtheria/Pertussis) recommended.**
- **Submit evidence of immunization.**

6. **Health Insurance: Hospitalization Insurance Information Form.** MUSC policy requires that all students have current medical/hospitalization insurance to cover them during the course. Provide the following information: **ATTACH A COPY OF YOUR INSURANCE CARD.**

a. Insurance Company

Name: _____

b. Major Medical Coverage: ____ Yes ____ No

c. Policy Holder: (Circle one) Self Spouse Parent

- Name of Policy Holder _____
- Policy Identification Number _____

I, _____, attest the above information is accurate.

Name (print)

Signature

Date

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA
99 JONATHAN LUCAS STREET
MSC 160
CHARLESTON, SC 29425**

**REPORT OF PHYSICAL EXAM
(Completed within 3 months of application to course)**

TO: DIRECTOR, WOUND CARE EDUCATION PROGRAM

REGARDING: _____
Name of Individual Examined (print)

Date of Examination: _____

I have examined the above named individual and find him/her in good physical and mental condition, free of communicable diseases, and able to perform all work, classroom, and clinical duties.

Other Comments:

Name of Physician: Print _____
Last First Middle Professional designation

Address: _____

Telephone: _____ Fax: _____

Email: _____

Physician Signature/Professional designation/Credential Date

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA
99 JONATHAN LUCAS STREET
MSC 160
CHARLESTON, SC 29425**

Note: These sections (Addenda I-V) required for split-option, web-enhanced distance learning course applicants only.

ADDENDUM I

ACKNOWLEDGEMENT OF COMPUTER SKILLS/ EQUIPMENT REQUIREMENTS

Directions: Please read and complete the information requested. Sign the form and return it with the application packet.

Access to communication via computer: Students must possess basic word processing and file-management skills and have the ability to use Email and Internet services for transmission of files and conduct library searches. Students will be held accountable for information from faculty disseminated via electronic mail. Students must submit a correct email address, fax number, and phone number with the admission packet, and are responsible for notifying the Program Director immediately of any changes:

- An in-home computer with a modem and Internet Service Provider is required.
- Email capability is required. Email address: _____
- Access to a fax machine is necessary: In-home preferred: (number) _____
- Home telephone voice mail or answer machine required: (number) _____

Minimum Computer/Hardware Recommendations:

- Pentium processor or equivalent, 233 MHZ or faster
- 56k Modem
- 64 MB RAM
- 4 GB Hard Drive
- 3.5" 1.44 Floppy Drive
- Printer

Minimum Software Requirements

Internet Browser Preferred:

- **Windows Browser**
Microsoft Internet Explorer: 5.0, 5.5, 6.0
Netscape: 6.2.x, 7.0
AOL: 7.0, 8.0
- **Macintosh OS Browser**
Microsoft Internet Explorer: 5.1 (OS 9.x and OS X.1) and 5.2 (OS X.2)
- Netscape 6.2
- AOL: OS X
- If AOL is your ISP, download and install and use Netscape or Internet Explorer (IE) only. **Do not use proprietary AOL versions of these browsers that are imbedded in the AOL software. WebCT, on-line course software, which is used for the examinations, will not function properly with the imbedded IE or Netscape browser in AOL client software.**

- Acrobat Reader Software with Acrobat PDF Companion. To download, go to www.Adobe.com
- Java and Java Script must be enabled in your browser of choice
- Name/type of your Computer _____ Amount RAM _____
- Name of browser _____ Printer _____
- Internet Service Provider _____
- Specify Operating Systems: Windows 2000 and Above _____ or Macintosh OS 7.6 and Above _____
- Office suite: Current version of Microsoft Word. **Must be able to transmit files in Word format.** Yes ____ No ____
- Java Script enabled. Yes _____ NO _____
- Adobe Acrobat Reader downloaded. Yes _____ NO _____

Technology Support

Neither MUSC, nor the faculty and staff of the Wound Care Education Program are responsible to provide the computer equipment or skills needed to complete the course. It is the sole responsibility of the student to have access to the required computer equipment and software, to insure that the computer equipment and software is installed properly, to maintain or repair the hardware/software, and obtain or possess the computer skills necessary to complete the required on-line activities and assignments. The Program Director will communicate and coordinate with Technological Support at MUSC to resolve any problems related to the site and server at MUSC but cannot provide technology support to individuals.

If an individual student encounters a technical problem with their personal equipment, they should **first** check with the technology support services from their Internet Service Provider or the equipment manufacturer or supplier to resolve the issue. The Director must be notified if the problem will delay completion of an assignment beyond the due date.

In the event problems are encountered with on-line activities (Email, bulletin board, chat room discussions, or WebCT), the student is to notify the Director immediately by telephone or fax. Written assignments or bulletin board postings can be submitted to the Director by fax or regular mail if needed. On-line chats that are missed completely by everyone due to technology failures will be re-scheduled by the Director. Server related problems with WebCT (e.g., server not responding) for the on-line examinations should be reported to the Center for Computing Information Technology (CCIT) Help Desk at 843-792-9700 and the ARCS on-call person will be paged. If verifiable technical problems with the server prevent the administration of a scheduled examination, the examination may be rescheduled or a paper form of the exam may be arranged at the discretion of the Director after a review of the circumstances.

I hereby acknowledge that I have read, understand, and agree to comply with the above requirements. By my signature below I certify that I possess the specified computer skills and the necessary equipment

Student Signature

Date

ADDENDUM II: SELF-ASSESSMENT DISTANCE LEARNING SURVEY*

Instructions to Applicant: Read each item and check the statements that best describe you and your study habits.

Check all responses and add the number of statements checked in each column. Enter the totals as indicated in the blanks at the end of the form. This form is to be submitted to Program Director for review with the application packet.

Column A	Column B
I sometimes have 16-20 hours per week to spend on this course, but many times I do not	I have 16-20 hours a week to spend on this course
I plan to schedule my distance learning course work around my other usual family, work, and recreational activities	I have specific days/times available to work on my course lessons
I work well independently but I prefer having someone to check with regularly	I like to work on my own and seldom need reassurance that I am doing things correctly
I benefit from studying with a partner or study group	I would rather read material in a textbook than listen to a lecture
When learning a new skill, I would rather watch someone demonstrate the skill than listen to someone tell me how to do it	I have met the computer hardware, software, and skills requirements for this course
I would rather listen to a lecture than read material in a book	I recognize that the class work for a distance learning course is equal to or greater than that of a regular course and plan to make arrangements for time to study and work on the course
I would not feel comfortable contacting an instructor for help	I am a good reader and enjoy learning by reading
I prefer getting an immediate answer to a question rather than waiting	I realize that course requirements and due dates are there for good reasons and I feel I can structure my time effectively to meet them
I have not met the computer hardware, software, skills requirements for this course	I realize my instructor may not be available when I want and that I may have to leave an E-Mail or voice-mail message
I am an ok reader but I prefer to have an instructor present the material	I would rather have written directions than oral directions
I work better when someone tells me what to do	I learn better by doing than observing
I want to take this distance learning course because there is probably less work to do than in a regular course	I am willing to take responsibility for getting whatever help I may need with this course by contacting an instructor
I know course requirements and due dates are there for good reasons, but I feel exceptions should be made if I get behind on my work	I can find the mistakes in my written work
My experience with computers, Email, the World Wide Web, and using word processing software is limited	My experience with computers, Email, the World Wide Web, and using word processing software is moderate to extensive
I often have difficulty meeting time expectations and deadlines	I usually manage my time well and set priorities to accomplish tasks
I have minimal experience in wound care	I am somewhat experienced in wound care
I usually have difficulty with standardized exams	I usually do well on standardized exams
I do not have access to WOCN clinical preceptors	I have access to WOCN clinical preceptors

*(Adapted from on-line learning surveys from St. Louis Community College and tool by Catherine Jester of Diablo Valley College, 3/2001)

Total from Column A _____ **Total from Column B** _____

Assessment: *A greater number of checks in Column A indicate that distance learning may not be the most effective way for you to learn.* A greater number of checks in Column B suggest that distance learning may be appropriate for you. Distance learning requires excellent time management skills and independent, self-motivated learners.

Name of Applicant _____ Date _____

Director Signature _____ Date reviewed _____

ADDENDUM III

PROCTORED EXAMINATION PROCEDURE/CRITERIA

Two on-line, password protected, computer based examinations are given during the course. The Midterm Examination is scheduled halfway in the course and the Comprehensive Examination during Week 16. Specific dates and times of availability will be posted by the first date of the course. Each test is 2.00 hours in length.

Criteria for Examinations and Proctor

Each student is required to furnish a signed agreement from a qualified proctor who agrees to be physically present throughout the Midterm and Comprehensive Final Examination. **The proctor MAY NOT be a relative, spouse, friend or immediate co-worker.** The following are examples of individuals who may serve as a Proctor: Clinical Preceptor, Clinical Supervisor, Department Head or Manager, Staff Development Director, Minister/Rabbi/ Priest, university or school of nursing teacher, advisor, or counselor. Other candidates may serve if authorized by the Program Director in advance.

Directions for proctoring the Examinations:

1. Proctor must be physically present and oversee the complete examination.
2. Room used for the test must be in a private area free of distractions, interruptions.
3. Student may not converse with anyone other than the proctor once the examination has started until the examination is completed.
4. Password to access the Examination will be provided only to the Proctor who will furnish the password directly to the student at the time and location of the examination.
5. Proctor insures that student named on this form is the individual taking the examination.
6. Picture ID and one other form of identification are required for the Proctor to verify identification.
7. Examination is not an open book test. Use of books or journals or any reference material is strictly prohibited and student may not have any notes, books, papers, or reference material in the room during the examination.
8. Cell phones, pagers, cameras, and all other communication/electronic devices are strictly prohibited during the exam. No outside form of communication is allowed with anyone during the examination.
9. Student may have a pencil and 2 plain, blank sheets of paper, which are to be furnished by or checked by the Proctor. The sheet of paper must be returned to the proctor after the exam and is to be immediately destroyed by the Proctor.
10. No notes may be made about the exam or questions and taken from the room after the exam.
11. Examination may not be printed or downloaded in any form from the website.
12. Any violations of these procedures by the student are to be reported to the Director by the Proctor and will result in the Student receiving a grade of "Zero" for the examination.

Student & Proctor Verification Statements: This form is to be signed, dated and returned to the Program Director at the completion of the examination. The envelope should be sealed with the Proctor's signature across the seal.

I hereby verify that I completed the (Midterm, or Final Examination) on Date _____ Time _____

Student Signature

I hereby verify that the above named individual took the Examination at the time/date specified and adhered to all criteria specified above. I was physically present throughout the examination and certify that the exam was taken without the aide of any reference materials. No notes or copies were made related to the exam, and that I have destroyed any and all notes made during the examination

Proctor Signature

Date

**ADDENDUM IV
STUDENT/PROCTOR AGREEMENT FOR EXAMINATION PROCEDURE**

Directions: This Agreement is to be completed and signed by the Student and Proctor and submitted to the Program Director with the application packet.

STUDENT AGREEMENT STATEMENT

I have read and agree to abide by the rules set forth regarding the Proctored Examination Procedures/Criteria for the Midterm and Comprehensive Final Examination.

Student Name (Print): _____ Title: _____

Home Address: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

Fax: _____ Email: _____

Student Signature

Date

PROCTOR AGREEMENT STATEMENT

I agree to serve as an Examination Proctor for the Above Named Individual. I have read and agree to abide by the rules set forth regarding the Proctored Examination Procedure/Criteria. I agree to immediately report any and all violations or problems related to the Examination(s) to the Program Director.

Proctor Name (Print): _____ Title: _____

Home Phone: _____ Work Phone: _____

Fax No: _____ Email: _____

Home Address: _____

Work Address: _____

Occupation: _____

Are you a relative, spouse, friend or immediate co-worker? Yes _____ No _____

For how long and in what capacity do you know the Student?

Proctor Signature

Date

ADDENDUM V: OFF-SITE DISTANCE PRECEPTOR FORMS
Wound Care Education Program
College of Nursing
Medical University of South Carolina
Ph: 843-792-4630 or 2651/ Fax: 843-792-3680
Email: bonhamp@musc.edu

BIOGRAPHICAL DATA FORM FOR OFF-SITE CLINICAL PRECEPTOR (S)

Direction: Please print or type information clearly and attach requested information as indicated.

NAME: _____ **SOCIAL SECURITY #:** _____
Current RN Licensure #: _____ Date of Renewal: _____
State of current licensure: _____ (*Provide copy of current license*)
Current CPR certification: Certification effective to: _____ (*Provide copy of current CPR certificate*)

HOME ADDRESS:

Street Address

(City, State, Zip)

BUSINESS ADDRESS:

Name of Employer, Department: _____
Street Address: _____
City, State, Zip: _____
Phone (work): _____ Phone (home): _____
Email (work): _____ Email (home): _____
Fax (work): _____ Fax (home): _____
Is employing agency currently accredited? Yes ___ No ___
(*Please attach evidence of current accreditation (JCAHO or licensure)*)

PRESENT POSITION TITLE AND BRIEF DESCRIPTION OF DUTIES/RESPONSIBILITIES:

EMPLOYMENT HISTORY (CHRONOLOGICAL STARTING WITH MOST RECENT):

Institution	Position	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION BACKGROUND: COLLEGE THROUGH HIGHEST DEGREE

Institution & Location	Area of Study or Certification	Degree	Year Awarded
1. _____			
2. _____			
3. _____			
4. _____			

CERTIFICATION INFORMATION: (Enclose copy of current WOCNCB certification).

1. Please check all current Specialty Certification(s) you hold:
CWCN__, CWOCN__, COCN__, CCCN__, CWON__, Other_____,
(specify)_____.
2. How long have you been a WOCNCB certified Nurse? _____ years.
3. Date of Initial WOCNCB Certification: _____Recertification Due Date: _____.
4. Name/Location WOCNEP Program graduated from: _____.
5. Date graduated from WOCNEP Program: _____.
6. Did you qualify to certify by WOCNCB by the experiential track? Yes ____ NO ____.

CONTINUING EDUCATION RELEVANT TO WOUND CARE/PRECEPTOR ROLE (TITLE, DATE, LOCATION) WITHIN 2 YEARS:

PUBLICATIONS IN PEER-REVIEWED JOURNALS: _____ (LIST OR ATTACH CV).

PROFESSIONAL EXPERIENCES: Describe teaching, practice, or research activities that contribute to your clinical/teaching expertise.

PRECEPTOR EXPERIENCES: Describe prior experience as a preceptor, clinical nursing instructor, or provide evidence of attendance at a preceptor workshop.

TEACHING/LEARNING PHILOSOPHY: Describe your teaching/learning philosophy and role of clinical preceptor as it relates to student learning experience.

Signature: _____ **Date:** _____

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA**

**OFF-SITE PRECEPTOR ANNUAL CLINICAL STATISTICS REPORT
YEAR: _____**

Name/credentials of Preceptor: _____

Facility: _____

Directions: Please provide a report of your *average daily census of wound patients* for the most recent year. In each column, identify the average number of patients on your census for each type wound and setting per day.

Type Patient	Acute Care	Out-patient	Home Health	ECF/SNF	Other (specify)
Surgical Wounds					
Pressure Ulcers					
Vascular (venous/arterial)					
Neuropathic/diabetic ulcers					
Skin Irritation or Infection					
Fistulae					
Percutaneous Tubes/Drains					
Foot/Nail Care					
Other Wounds or Skin Problems					

A. If you have any of the following experiences available to enhance students learning, place a check by the experience:

Vascular laboratory _____ Spinal Cord Clinic _____
 Hyperbaric Oxygen Therapy _____ Electrical Stimulation _____
 Hydrotherapy _____ Instrumental Debridement _____
 Laser Therapy _____ Burn/Trauma Center _____
 Foot Clinic _____ Other (Specify) _____

B. How many total patients do you see on an average clinical work day? _____

Signature: _____

Date: _____

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA**

OFF-SITE PRECEPTOR CHECKLIST

OFF-SITE CLINICAL PRECEPTOR NAME:

OFF-SITE FACILITY NAME/LOCATION:

DATE:

THE FOLLOWING CHECKED ITEMS ARE NEEDED TO COMPLETE OUR FILES:

_____ Biographical Data Form for Off-Site Clinical Preceptor

_____ Completed Preceptor Annual Clinical Statistics form

_____ Copy of Current WOCNCB Certification

_____ List of continuing education courses attended in the past 2 years relevant to wound care or preceptor role.

_____ Copy current Joint Commission Accreditation Certificate (or State accreditation if Home Health Care Agency) for employing facility.

_____ Copy current CPR certificate

_____ Copy current/valid RN license

_____ Signed Acknowledgement of Preceptor Responsibilities form

_____ Affiliation Agreement Request Form: Clinical Preceptor form

_____ Annual Evaluation of Course by Preceptor form

Comments:

If you have any question regarding this request, feel free to call
Phyllis Bonham, PhD, MSN, RN, CWOCN, DPNAP
Associate Professor
Director, Wound Care Education Program
Phone: 843-792-2651; Fax: 843-792-3680
Email: bonhamp@musc.edu

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA**

**ACKNOWLEDGEMENT OF PRECEPTOR RESPONSIBILITIES
OFF-SITE CLINICAL**

Each clinical preceptor is responsible for selecting patients for student experience and for providing clinical instruction/guidance.

1. The Preceptor will orient the student to the following: (a) overview of agency, rules, and guidelines (b) preceptor role and responsibilities, and (c) student role and responsibilities.
2. The Preceptor will facilitate clinical learning and correlation of didactic instruction and clinical practice by: (a) assessing the student's learning needs and knowledge base, (b) reviewing the patient's history or medical record with the student, and assisting the student to identify care needs and appropriate interventions prior to seeing the patient, (c) assisting the student to identify alternative treatment options, (d) providing assistance to the student (as needed) in delivering and documenting appropriate patient care, teaching, and counseling; and (e) intervening when appropriate to correct problems or make improvements in the student's assessment of patient care needs, delivery of care, or documentation.
3. The Preceptor will evaluate the student's performance and will provide feedback to the student and Director of the Wound Care Education Program regarding the student's clinical performance. Evaluation is based on stated course objectives. The preceptor is asked to complete the student's written evaluation at the end of the rotation and to give him/her verbal feedback and evaluation throughout the rotation. *Written feedback on the Clinical Evaluation Form (provided by wound program) is submitted to the Director of the Wound Care Education Program who is responsible for final determination as to whether or not a student has satisfactorily completed the clinical component of the course.*
4. **The Preceptor will promptly notify the student and the Wound Care Education Program Director of any concerns, problems, or deficits regarding the student's clinical performance.**
5. The Preceptor assists each student in identifying issues related to role implementation and coordination of services as it affects the delivery of patient care.
6. The Preceptor participates in development, implementation, and evaluation of the wound program as requested.
7. The Preceptor will provide evidence of at least one-year, full-time clinical practice in wound specialty after certification, maintain current WOCNCB Board Certification, and submit evidence of current Certification upon request.
8. The Preceptor will maintain and submit annual clinical statistics re: patient census per setting.
9. The Preceptor will provide evidence of attending at least 1 relevant education program per 1-2 year(s).
10. The Preceptor will provide evidence of current/valid state Nursing (RN) license, CPR, and agency accreditation.

I have read and agree to the responsibilities of the clinical preceptor.

Signature: _____ **Facility:** _____ **Date:** _____

**WOUND CARE EDUCATION PROGRAM
COLLEGE OF NURSING
MEDICAL UNIVERSITY OF SOUTH CAROLINA**

OFF-SITE AFFILIATION AGREEMENT REQUEST FORM: CLINICAL PRECEPTOR

DIRECTIONS: This form is to be completed by the student (or preceptor) requesting an off-site clinical affiliation agreement for the Split-Option, Web-enhanced, Distance Learning Wound Course and returned to the Director of the Wound Care Education Program with the Application Packet.

FACILITY INFORMATION: Please type or download and complete on computer.

1. Complete legal name of facility: _____
2. Address of facility (street, city, state, zip): _____
3. Organization telephone number (area code): _____ Organization Fax: _____
4. Name of Contact Person at Facility: _____ Title: _____
5. Contact Person Phone: (____) _____ Fax: _____
6. Contact Email: _____

The following information is requested for the University Clinical Sites Database:

- | | |
|--|----------------------------|
| Will site accept multiple assignments? | Yes ___ No ___ Unknown ___ |
| Does site provide housing? | Yes ___ No ___ Unknown ___ |
| Is facility in a health professional shortage area (HPSA)? | Yes ___ No ___ Unknown ___ |
| Is facility a medically underserved area (MUA)? | Yes ___ No ___ Unknown ___ |
| Is facility a rural clinic? | Yes ___ No ___ Unknown ___ |
| Is facility a community health center? | Yes ___ No ___ Unknown ___ |
| Is facility a Federally qualified health center (FQHC)? | Yes ___ No ___ Unknown ___ |
| In which county is facility located? | _____ |
| *Is facility owned by a parent company? | Yes ___ No ___ Unknown ___ |

*If yes, provide the following information on the Parent Company:

PARENT COMPANY INFORMATION:

Complete legal name of Parent Company: _____
Address of Parent Company (street, city, state, zip): _____
Telephone: _____ Fax: _____
Contact Person at Parent Company (name/title): _____
Telephone of Contact Person: _____ Fax: _____
Email of Contact Person at Parent Company: _____

PRECEPTOR INFORMATION:

1. Preceptor Name: _____ Credential: _____
2. Work Address: _____
3. Home Address: _____
4. Phone: W (____) _____ Fax: (____) _____ Home: (____) _____
5. Email Work: _____ Home: _____

STUDENT INFORMATION:

Student's Name: _____ Date to start clinical experience: _____
Email: _____ Phone: _____ Fax: _____

FACULTY MEMBER SUBMITTING REQUEST:

Name: _____
Email: _____ Phone: _____ Fax: _____

COMMENTS:

(6-29-09)