Fitness for Professional Practice form

STUDENT NAME: _____ STUDENT ID: _____

The abovenamed student has disclosed to the College of Nursing & Health Sciences that they have a medical, emotional, physical or psychological condition that may affect their ability to undertake clinical practice.

Students must meet a range of **clinical standards** while undertaking placement including:

- the ability to communicate professionally with staff, patients and relatives
- the ability to work with a diverse range of clients
- the ability to manage time
- the ability to participate in a rapidly changing workplace
- the ability to work where conflict may occur
- the ability to think and act quickly.

Students must undertake a range of **activities** while on placement including:

- pushing/pulling trolleys
- standing for a period of time
- sitting for a period of time
- walking for a period of time
- climbing stairs
- kneeling
- squatting
- working above shoulder height
- working below knee height
- undertaking tasks with both hands and easily alternating between the hands.

To be completed by the student's treating doctor:

Do you have any concerns about this student's capacity to meet the above **clinical standards**? ☐Yes ☐No

If yes, would you please describe these concerns? _____

_____

_____

Do you have any concerns about this student's capacity to undertake the above **activities**? ☐Yes ☐No

If yes, would you please describe these concerns? _____

_____

_____

Do you wish to make recommendations to the College of Nursing & Health Sciences that you believe will assist this student to meet these standards & activities? ☐Yes ☐No

If yes, would you please describe these recommendations? _____

_____

Are there any special equipment/resources that could be provided to assist this student to meet these practice standards and activities while on clinical placement? ☐Yes ☐No

If yes, would you please describe the special equipment/resources? _____

_____

Do you believe this student to be fit to undertake professional practice at this time? ☐Yes ☐No

If No, when do you believe they will be fit? _____

_____

Dr's Name: _____ **Provider Number:** _____

Signature: _____ **Date:** _____

Practice Stamp or Address Here