Wallace Community College
Associate Degree Nursing Program

HEALTH ADDENDUM FORM

To the Healthcare Provider:

(Student Name)_____, presenting this form gives permission for release of information to the Nursing Department of Wallace Community College and the student requests your professional opinion in helping to evaluate the student's ability to perform required nursing program course work.

Student Signature_____Date_____

If you have any further questions, please contact Dr. Rayanne Daniels, Associate Degree Nursing Director, rdaniels@wallace.edu. Thank you for your time and attention to this request.

Please return this form to the student

PROVIDER STATEMENT: Due to ☐illness, ☐injury, ☐surgery, ☐pregnancy, ☐other_____ on (date/s)_____, there has been an alteration in the physical health status of the nursing student named above. In my professional opinion the student is released to safely resume the nursing activities related to course work on_____(date) without endangering safety and health of patients or self and meets the ***Eligibility Criteria*** of the Nursing Program.

Please indicate any accommodations or restrictions for the following nursing activities. If ANY restrictions, also indicate the end date:

Nursing Activity	NO Restrictions	With Weight Restriction	With Time Restriction	NOT Allowed	Resume on (date):
1. Walk without a cane, walker or crutches					
2. Lift, Turn, Transfer with assist					
3. Stand, bend, walk or sit in clinical setting without harm to safety of the patient, self or others					
4. Perform daily care functions for the patient					
5. Perform CPR and physical assessment					
6. Administer Medications					
7. Respond rapidly to emergency situations					
8. Demonstrate a mentally healthy attitude					
9. Interact with patients with a variety of physical and/or psychiatric illness					
10. Not pose a threat to self or others					
11. Function effectively in situations of stress inherent in healthcare					
12. Other: (List)					

Provider's Signature:_____**(**MD, DO, CRNP, PA)

PRINT Provider's Name**:**_____Provider's Phone Number: _____

Provider's Address_____City:_____State:_____ZIP: _____