Fitness for clinical practice form

Student name: ................................................................................................................

Student ID number: ........................................................................................................

Year Level: .....................................................................................................................

The above student has disclosed to the School of Nursing & Midwifery that they have a medical, emotional, physical or psychological issue that could affect their ability to undertake clinical practice.

As nursing and midwifery is a practice discipline, our program requires students to meet a range of clinical competencies while undertaking clinical placement.

These clinical competencies include:

- the ability to communicate appropriately with staff, patients and relatives
- the ability to work with confused clients
- the ability to manage time
- the ability to participate in a rapidly changing workplace
- the ability to work in areas where conflict occurs
- the ability to think and act quickly.

Our program also requires students to undertake a range of tasks while on clinical placement.

These tasks include:

- 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.
As ....................................................................................’s treating doctor: 
(student name)

- Do you have any concerns about this student’s ability to meet these **clinical competencies**?
  - Yes/No
  - If yes, would you please describe these concerns?
    ........................................................................................................................
    ........................................................................................................................
    ........................................................................................................................

- Do you have any concerns about this student’s ability to undertake these **tasks**?
  - Yes/No
  - If yes, would you please describe these concerns?
    ........................................................................................................................
    ........................................................................................................................
    ........................................................................................................................

- Do you wish to make recommendations to the School of Nursing & Midwifery that you believe will assist this student to meet these competencies & tasks?
  - 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 clinical competencies and tasks 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 meet these competencies **at present**?
  - Yes/No
  If **No**, when do you believe they will be fit?
    ........................................................................................................................
    ........................................................................................................................

Drs name and provider number: .................................................................
Date: .................................................................................................
Contact phone number: ......................................................................