

Must be prepared on your school's official letterhead-then delete this line

**TRAINEE QUALIFICATIONS AND CREDENTIALS VERIFICATION LETTER (TQCVL)
FOR TRAINEES SPONSORED BY**

*Department, Program, or Sponsoring Entity
School's Mailing Address
City, State, Zip Code*

Yvette Falero-Cruz
Mail code 118-E
James A. Haley VA Hospital
13000 Bruce B. Downs Blvd.
Tampa, FL 33612

Dear Yvette Falero-Cruz:

I certify that the information listed in paragraph 2 has been verified for the trainee listed below is scheduled to receive clinical training at Tampa JAHVA:

Starting Date:		Ending Date:	
Clinical Hours		Degree Sought (circle)	DNP, PhD, MSN or ARNP

Trainees Full Name	
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Clinical Area needed (Based on the clinical objectives)	Date of TMS Mandatory Training (Exempt for VA Nurses)	Students email	Students Phone number
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	__ / __ / __		
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Preceptor name	SCHOOL COORDINATORS NAME AND CONTACT INFORMATION	Included: A Copy of clinical objectives
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		YES NO
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1. This healthcare trainee:
 - i) Is enrolled in the designated training program and have met criteria for this level of training.
 - ii) Has the following:
2. Primary source verification of educational credentials as required by the admission criteria of the affiliate's training program.
3. Has had primary source verification of current licenses including provisional, temporary, or training licenses, registrations, or certifications through the state licensing boards and national and state certification bodies as required by the training program.

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- 4. Credentials subject to verification include all prior or current licenses, certifications, or registrations in any clinical program and has provided letters of reference as required by training program.
- 5. I will notify the Director of Affiliations for Nursing within 72 hours of changes in the academic status of individual trainees, adverse actions that affect the trainee appointment, or changes in health status that pose a risk to the safety of trainees, other employees, or patients.
- 4. I certify that all documents pertaining to the listed trainees are maintained on file and available to VA officials for review.



Signature: _____ (Date)

Name: _____
Nursing Program Director

Telephone: _____

Email address: _____

----- **PART II** (to be completed by a Licensed Health Care Provider) -----

I certify that this student has satisfactory health to perform the duties of the clinical training program; has completed tuberculin testing as required by the Center for Disease Control (CDC) and VA facility standards, hepatitis B vaccination or have signed declination waivers and has chicken pox or chicken pox vaccine or have signed declination waivers.

Signature: _____ (Date)

Name: _____
Health Care Provider

STUDENTS MUST SIGN:

- I understand that I must complete a new QTCVL for each clinical opportunity.
- Completing a QTCVL does not secure future clinical.
- Clinical must be approved by the Trainee Program Director for Nursing.
- I will turn in my student badge to the Trainee Program Director for Nursing on the end date listed above.

Student Signature: _____ (Date)

Received by the Director of Affiliations for Nursing (Date)

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James A. Haley VA
Tampa, Fl.