Student/Faculty Clinical Passport

This is a digital PDF and should not be handwritten.
For best results, we recommend the free version of Adobe that can be downloaded by clicking here
For more information on this Clinical Passport click here

By contract with your academic institution, all students and faculty participating in learning experiences at this healthcare site must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met prior to participation in the clinical experience. Records will be kept at the academic institution and random review by the clinical affiliates will occur on a regular basis. Documentation must meet requirements at all times. Required immunizations must include mm/dd/yyyy if available.

Student/Faculty Name: _____ DOB: _____
College: _____
Program: _____
Student Employment Facility: _____

Form Verified By: Name: _____ Date _____
Name: _____ Date _____
Name: _____ Date _____

SUBMITTED ONCE

☐ **TUBERCULIN STATUS** The Tuberculin requirement can be met through completion of one of the following:

A. Two-step TST#1

Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos
If first TST is positive or new positive with no history of disease then an IGRA and provider examination with Chest XRay is recommended to confirm.

Two-step TST#2

Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos **OR**

B. TB IGRA Date: _____ Result: _____

C. New positive, date of exam/chest xray: _____

D.History of positive results Date: _____ (Self Screening)

☐ **HEPATITIS B** The Hepatitis B requirement can be met through completion of one of the following:

A. 3-series (Recombinex HB or Energix-B or Recombivax HB) Series shots at 0, 1, 6 months plus titer confirmations 6-8 weeks later.

Vaccination Dates:

1. _____ Titer:
2. _____ Date drawn: _____
3. _____ Result: ☐ Neg ☐ Pos

If negative titer after initial series of 3 vaccines, then vaccine #4 and re-titer OR #5 and #6 vaccines and re-titer

4. _____ Titer:
5. _____ Date drawn: _____
6. _____ Result: ☐ Neg ☐ Pos **OR**

B. 2-series (Heplisav)

Vaccination Dates: Titer:

1. _____ Date drawn: _____
2. _____ Result: ☐ Neg ☐ Pos

If negative titer after initial series of 2 vaccines, then vaccine #3 and re-titer and #4 vaccines and re-titer

3. _____ Titer:
4. _____ Date drawn: _____
Result: ☐ Neg ☐ Pos

C. Immunity by titer (anti-HBs or HepB SAb)

Date: _____

D. Non-converter: Must provide series information above.

☐ Yes

E. Signed Series in Process Form Date: _____

☐ **MMR** (Measles, Mumps, Rubella) **OR MMRV** (Measles, Mumps, Rubella, Varicella). MMRV if received prior to the age of 12.

A. Vaccination Dates

1. _____ 2. _____ **OR**

B. Immunity by titers: Measles titer Date: _____
Mumps titer Date: _____
Rubella titer Date: _____

☐ **VARICELLA**

A. Vaccination Dates

1. _____ 2. _____ **OR**
Immunity by titer Date: _____

☐ **TETANUS/DIPHTHERIA/PERTUSSIS** 1 dose of Tdap required followed by a dose of Td or Tdap every 10 years.

A. Initial Tdap Date: _____ **B. Td/Tdap** Date: _____

SUBMITTED YEARLY

☐ **TUBERCULIN STATUS** Annual Tuberculin Status must be given less than one year from the administration date. Annual TST requirement may be met through completion of one of the following:

A. 2-step TST

Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos
Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos

B. 1-step TST

Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos
Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos
Place Date: _____ Read Date: _____
Result _____mm ☐ Neg ☐ Pos

C. Annual TB IGRA

Date: _____ Result: _____
Date: _____ Result: _____
Date: _____ Result: _____

D. If New Positive TST or IGRA Exam/Chest X-ray

Date of exam/chest xray: _____
Complete annual symptom check form. Date: _____

E. For Known History of Positive/Possible Treatment:
Complete Annual Symptom Check form: (Self Screening)
Date of exam/chest xray: _____

☐ **INFLUENZA** Include name of provider or location where the vaccination was received (CVS, Walmart, health dept., etc.) (location address is NOT required)

A. Healthcare administered seasonal vaccination

Provider/Agency _____ Date: _____
Provider/Agency _____ Date: _____
Provider/Agency _____ Date: _____

☐ **BACKGROUND CHECK**

A. National Criminal Background Check Including the Exclusion Provider Search on OIG and GSA upon admission.

Date: _____

B. Washington State Patrol Check (WATCH) upon admission and then annually.

Date: _____ Date: _____
Date: _____ Date: _____

C. Criminal History Disclosure (School keeps this on file) This is to be completed at the same time as WATCH, annually.

Date: _____ Date: _____
Date: _____ Date: _____
Need a Disclosure form? Click Here

D. Provider Search: OIG/GSA—Automatically (run bi-monthly on 1st and 15th of every month per CPNW) Student on-boarded before cycle: manually run on

Date: _____

☐ **AHA/BLS COURSE** (Course must be American Heart Association (AHA) BLS provider.)

A. Expiration Date: _____ Expiration Date: _____

☐ **INSURANCE**

A. Professional Liability Policy
Expiration Date: _____; _____;

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SUBMITTED ONCE

☐ **COVID-19 VACCINATION** Confirm with the Site Requirements on the CPNW website to determine specific COVID-19 vaccination requirments.

A. Vaccine Information

Manufacturer: _____ 1or 2 dose series: _____

Date of first dose: _____ Date of second dose: _____

☐ **RESPIRATOR DOCUMENTATION** *Verify with Academic/Program Coordinator for more information regarding this standard. If directed by Program Coordinator complete the following:

A. Biennial Respiratory Medical Questionnaire complete?

☐ Yes, date completed: _____ ☐ No

B. Annual Respiratory Fit Test Record complete?

☐ Yes, date completed: _____ ☐ No

*Individual forms from different organizations are acceptable alternatives if the content is the same. Please ensure forms are uploaded to user's CPNW account.

- Respiratory Medical Questionnaire
- Respiratory Fit Test Record

☐ **AUTHORIZATION FOR RELEASE OF RECORD**

(School keeps this on file)

☐ **MILITARY IMMUNIZATION** Exempt Status for certain vaccines according to military code are acceptable. Upload military exempt status paperwork to account users CPNW folder.

- Exempt status for certain vaccines according to military code:

☐ Hepatitis B ☐ MMR ☐ Varicella

Click Here

☐ **ADDITIONAL REQUIREMENTS** (If Applicable) The healthcare organization may have additional requirements that must be completed.

Other

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

SUBMITTED YEARLY

☐ **COVID-19 BOOSTER and/or VACCINATION** Not all Healthcare facilities require annual boosters, confirm with the Site Requirements on the CPNW website. It is requested to include Booster information if available, even if not required.

A. Vaccine Information

Manufacturer: _____ Date: _____

Manufacturer: _____ Date: _____

Manufacturer: _____ Date: _____

☐ **RESPIRATOR DOCUMENTATION** *Verify with Academic/Program Coordinator for more information regarding this standard. If directed by Program Coordinator complete the following:

A. Annual Respiratory Fit Test Record complete?

☐ Yes, date completed: _____ ☐ No

*Individual forms from different organizations are acceptable alternatives if the content is the same. Please ensure forms are uploaded to user's CPNW account.

- Respiratory Fit Test Record

☐ **REQUIRED EDUCATION**

All students and faculty must complete ALL student learning modules on the CPNW website. Any questions, please consult your program.

☐ **LICENSE** (Any **healthcare** license, registration)

A. State:_____ License#_____

Expiration date:_____; _____;

_____; _____;

State:_____ License#_____

Expiration date:_____; _____;

_____; _____; **OR**

B. ☐ Not Applicable

☐ ***Office Use Only**

Pursued Exemptions:

Users must meet the health and safety requirements of the hosting facility. Inquiry for an exemption must be initiated through the educational institution.

Approved exemptions are to be uploaded to the individual's CPNW account.

Facility Name:_____ Date: _____

Exemption Type:_____

Facility Name:_____ Date: _____

Exemption Type:_____