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**
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. If new positive results Date _____ of Exam/X-ray
D.History of positive results Date:_____

☐ **HEPATITIS B** (3 primary series shots [at 0, 1, 6 months] plus titer confirmations 6-8 weeks later) **OR** (2 primary series shots [over 1-month period] plus titer confirmation 6-8 weeks later).
A. 3-series (Recombinex HB or Energix-B or Recombivax HB)
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. History of disease/non-converter 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: _____

☐ **COVID-19 VACCINATION**
A. Vaccine Information
Manufacturer: _____ 1or 2 dose series: _____
Date of first dose: _____ Date of second dose: _____

SUBMITTED YEARLY

☐ **TUBERCULIN STATUS**
A. Annual TST (given less than one year from previous TST)
Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos
Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos
B. Annual TB IGRA (drawn less than one year from previous IGRA)
Date:_____ Result:_____
Date:_____ Result:_____
Date:_____ Result:_____
C. If New Positive TST or IGRA Exam/Chest X-ray
Exam Date:_____ Result:_____
D. For Known History of Positive/Possible Treatment:
Complete Annual symptom check (Self Screening)
Date:_____

☐ **INFLUENZA**
A. Healthcare administered seasonal vaccination
Provider_____Date:_____
Provider_____Date:_____
Provider_____Date:_____

☐ **BACKGROUND CHECK**
A. National Criminal Background Check Including the Exclusion Provider Search on OIG and GSA upon admission.
Date:_____
B. 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:_____
C. Washington State Patrol Check (WATCH) upon admission and then annually.
Date:_____ Date:_____
Date:_____ Date:_____
D. Criminal History Disclosure (School keeps this on file)
This is to be completed at the same time as WATCH
Date:_____ Date:_____
Date:_____ Date:_____
Need a Disclosure form? Click Here

☐ **AHA/BLS COURSE** (Course must be American Heart Association (AHA) BLS provider.)
A. Expiration Date:_____ Date:_____

☐ **COVID-19 BOOSTER**
A. Vaccine Information
Manufacturer: _____ Date: _____
Manufacturer: _____ Date: _____
Manufacturer: _____ Date: _____

☐ **INSURANCE**
A. Professional Liability Policy
Expiration Date:_____; _____;

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

☐ **DECLINATIONS** *Approved program declinations and approved facility declinations are to be uploaded to the student CPNW account
COVID-19 ☐ Influenza ☐ Other ☐
Date: _____ Date: _____ Date: _____
* Any declinations need to be discussed between the program and the facility.

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☐ **AUTHORIZATION FOR RELEASE OF RECORD**
(School keeps this on file)

☐ **MILITARY IMMUNIZATION** (medical immunity)
- 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:_____

SUBMITTED YEARLY

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

A. State:_____ License#_____
Expiration date:_____; _____;
_____; _____;
State:_____ License#_____
Expiration date:_____; _____;
_____; _____; **OR**

B. ☐ Not Applicable