Clinical Placement Northwest Collaborative Student/Faculty Clinical Passport Requirements

Student/Faculty Name:

College:
Program:

These requirements are in place for the health and safety of students, faculty and their patients.

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met **prior** to participation in patient care/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.

SUBMITTED ONCE

TUBERCULIN STATUS

- If no previous records or more than 12 months since last TST 2 step TST **OR**
- QuantiFERON (QFT) TB Gold test within 12 months **OR**
- If negative TST within 12 months one step TST **OR**
- If newly positive TST F/U by healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and need to complete health questionnaire
- If history of positive TST provide documentation of TST reading, provide proof of chest X-ray documenting absence of M. TB, medical treatment and negative symptom check **OR**
- If history of BCG vaccine QFT. If negative OK; If positive do Chest X-Ray

HEPATITIS B

- Series of 3 vaccines completed at appropriate time intervals and post vaccination titer at 6-8 weeks after series completion
- If negative titer, then repeat series (consisting of doses 4-6) and repeat titer 6-8 weeks after #6 dose. **OR**
- Provide documentation of positive titer (anti-HBs) **OR**
- Signed waiver for students/faculty who decline vaccination
  Specific healthcare institutions may require vaccination without exception (i.e., no waiver)

MMR (Measles, Mumps, Rubella)

- Proof of vaccination (2 doses at appropriate intervals) **OR**
- Proof of immunity by titer

VARICELLA (Chicken Pox)

- Proof of vaccination (2 doses at appropriate intervals) **OR**
- Proof of immunity by titer

TETANUS,DIPTHERIA, PERTUSSIS (Tdap)

- Tdap **required** once
- Td required every 10 years after Tdap

CPR

- American Heart Association BCLS Healthcare Provider Certificate

AUTHORIZATION FOR RELEASE OF RECORD

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTY AND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN NURSING CLINICAL PLACEMENT DISTRICT #1(NCPD1) AND INLAND NORTHWEST CLINICAL PLACEMENT (INCPC) CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR NURSING PROGRAM.

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

- Annual TST **OR**
- Annual QuantiFERON TB Gold test **OR**
- If newly positive TST results F/U with healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and may need to complete health questionnaire.
- Previously documented +TST results and prior negative chest X-ray results: submit annual symptom check completed within one year from healthcare provider

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INFLUENZA

- Proof of annual vaccination(s) **OR**
- Signed waiver for student/faculty who decline vaccination
  Specific healthcare institutions may require vaccination without exception (i.e., no waiver)

BACKGROUND CHECKS

- National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/readmission and reentry/hire to nursing program to include all counties of residence, all Washington State counties per RCW 43.43.830 and OIG and GSA screens. Excluded provider search on OIG
  http://exclusions.oig.hhs.gov/search.aspx
  GSA http://www.sam.gov
- Washington State Patrol Background Check (WATCH) per RCW 43.43.830 through RCW 43.43.842 annually thereafter

LICENSE (if faculty licensed or certified as RN, LPN, or NAC in Washington State)

- Current
- Unencumbered

INSURANCE

- Professional Liability $1,000,000/3,000,000 policy

ADDITIONAL REQUIREMENTS (if applicable)

Some healthcare settings may have additional requirements, such as the following:

- *Vehicle Insurance (for access to VA & Military Facilities)*
- *Personal Health Insurance*
- *Drug Screen*
- *Hepatitis A Vaccine*
- *Current First Aid Card*
- *Proof of U.S. Citizenship*
- *Color Vision Test*

Students and Faculty will be informed prior to clinical experience if optional or additional requirements need to be met.

Clinical Placement Northwest Collaborative
Student/Faculty
Clinical Passport Requirements

Student/Faculty Name: _____ DOB _____
College: _____
Program: _____
Form verified by: _____
Name _____ Date _____
Name _____ Date _____
Name _____ Date _____

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met **prior** to participation in patient care/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.

SUBMITTED ONCE
Circle the applicable letter in each box.

☐ **TUBERCULIN STATUS**
A. Two-step TST 1) Skin Test #1 Date _____ Result: Neg☐Pos☐ mm:
2) Skin Test #2 Date _____ Result: Neg☐Pos☐ mm:
OR
B. QuantiFERON (QFT) Date:_____ Result:_____
OR
C. If New Positive/Exam/X-ray Date:_____
OR
D. Positive TST/Negative X-ray Date:_____

☐ **HEPATITIS B** (3 primary series shots: (at 0,1,6 mo) plus titer confirmation (6-8 weeks later)
A. Vaccination Dates
1) _____
2) _____
3) _____
Immunity confirmed by titer Date: **OR**
B. If negative titer after initial series of 3 vaccines, then vaccines #4-#6
4) _____
5) _____
6) _____
Immunity confirmed by titer Date: _____
C. Immunity confirmed by titer (anti-HBs) Date: _____ **OR**
D. Signed waiver Date: _____
E. Had the disease Date: _____

☐ **MMR** (Measles, Mumps, Rubella)
A. Vaccination Dates
1) _____ 2) _____ **OR**
B. Immunity by titers: Measles Date:_____
Mumps Date:_____ Rubella Date:_____

☐ **VARICELLA** (Chicken Pox)
A. Vaccination Dates:
1) _____ 2)_____ **OR**
B. Immunity by titer Date:_____

☐ **TETANUS/DIPTHERIA/PERTUSSIS**
A. Tdap Date:_____
B. Td Date:_____

☐ **AHA BCLS Healthcare Provider Certificate**
Expiration Date: _____

☐ **Authorization for Release of Record**

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTYAND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN NCPD AND INCPC CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR NURSING PROGRAM.

SUBMITTED EVERY YEAR
Circle the applicable letter in each box.

☐ **TUBERCULIN STATUS**
A. Annual TST
Date:_____ Result: Neg☐Pos☐mm☐
Date:_____ Result: Neg☐Pos☐mm☐
Date:_____ Result: Neg☐Pos☐mm☐
OR
B. Annual QuantiFERON (QFT)
Dates:_____,_____,_____**OR**
C. If New Positive/Exam/Chest X-ray
Exam Date:_____ X-ray Date:_____**OR**
D. Known Positive/Possible Treatment/ Annual Symptom Check from Health Care Provider
Date:_____

☐ **INFLUENZA**
A. Proof of annual vaccination
Date: 1)_____Date 2)_____ Date 3)_____
OR
B. Signed waiver
Date 1)_____Date 2)_____ Date 3)_____

☐ **BACKGROUND CHECK (including Disclosure Statement)**
A. National Criminal Background Check including Excluded Provider Search on OIG and GSA upon admission
Date:_____
B. Washington State Patrol Check (WATCH) upon admission and annually
Dates:_____,_____,_____,_____

☐ **LICENSE** (RNs, LPNs, NACs)
A. WA State Exp. Date:_____ **OR**
B. Not Applicable

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

☐ **ADDITIONAL REQUIREMENTS (if applicable)**
A. Vehicle Insurance Date:_____
B. Personal Health Insurance Date:_____
C. Drug Screen Date:_____
D. Hepatitis A Vaccine Two doses
Dates: 1. _____2). _____
E. Current First Aid Card Date:
F. Proof of U.S. Citizenship Date:
G. Confidentiality Statement Date:
H. Color Vision Test Date:

This is not a comprehensive list; there may be more items.