**Clinical Placement Northwest Collaborative**  
**Student/Faculty**  
**Clinical Passport Requirements**

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, DIPHTHERIA, PERTUSSIS (Tdap)
- Tdap **required** once
- Td required every 10 years after Tdap

#### CPR
- American Heart Association BCLS Healthcare Provider Certificate

### 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

#### 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.
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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 titer: Measles Date: ______ Mumps Date: ______ Rubella Date: ______

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

☐ TETANUS/DIPHTHERIA/PERTUSSIS
A. Tdap Date: ______
B. Td Date: ______

☐ AHA BCLS Healthcare Provider Certificate
Expiration Date: ______

☐ Authorization for Release of Record

REQUARED 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 NCPD AND INPC 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.