



Clinical Placements Northwest

Student/Faculty Clinical Passport Requirements

This is a digital PDF and should not be handwritten.

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.

| SUBMITTED ONCE | SUBMITTED EVERY YEAR |
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| <p>TUBERCULIN STATUS</p> <ul style="list-style-type: none"> Initial 2-step TST is required AND confirmation of initial 2-step completion. If no records of previous positive TB tests or more than 12 months since last TST then 2-step TST OR Negative TB IGRA test within 12 months OR If negative TST within 12 months → 1-step TST If newly positive TST or TB IGRA → F/U 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 results of TST reading, provide proof of chest X-ray documenting absence of M. TB, medical treatment and negative symptom check If history of BCG vaccine → TST Skin Testing as above or TB IGRA. If negative → OK; If positive → follow-up as above <p>HEPATITIS B</p> <ul style="list-style-type: none"> 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 obtain challenge dose #4 and re-titer after 6-8 weeks OR Provide results of positive titer (anti-HBs or HepB Sab) OR Signed declination for students/faculty who decline vaccination - Specific healthcare institutions may require vaccination without exception (i.e., no declination) <p>MMR (Measles, Mumps, Rubella)</p> <ul style="list-style-type: none"> Proof of vaccination (2 doses at appropriate intervals) OR Proof of Measles immunity by titer and Proof of Mumps immunity by titer and Proof of Rubella immunity by titer <p>VARICELLA</p> <ul style="list-style-type: none"> Proof of vaccination (2 doses administered at least 4 weeks apart) OR Proof of immunity by titer <p>TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)</p> <ul style="list-style-type: none"> Tdap required once after age 11 Td required every 10 years after Tdap <p>AUTHORIZATION FOR RELEASE OF RECORD</p> <ul style="list-style-type: none"> Kept on file by education institution <p>MILITARY IMMUNIZATION</p> <ul style="list-style-type: none"> If immunization occurred during Military service <p>ADDITIONAL REQUIREMENTS (if applicable) Some healthcare settings may have additional requirements, such as the following:</p> <ul style="list-style-type: none"> 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 Food Handlers License <p><i>Students and Faculty will be informed prior to clinical experience if optional or additional requirements need to be met.</i></p> | <p>TUBERCULIN STATUS</p> <ul style="list-style-type: none"> Annual TST OR Annual TB IGRA test If newly positive TST/IGRA 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 positive TST results and prior negative chest X-ray results. Complete Annual Symptom Check Form. If any “yes” responses → /F/U with healthcare provider. <p>INFLUENZA</p> <ul style="list-style-type: none"> Proof of seasonal vaccination(s) OR Signed declination for student/faculty who decline vaccination - Specific healthcare institutions may require vaccination without exception (i.e., no declination) http://flushot.healthmap.org/ <p>BACKGROUND CHECKS</p> <ul style="list-style-type: none"> National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/re-admission and re-entry/hire to program to include all counties of residence & all Washington State counties per RCW43.43.830 and OIG and GSA screens. Excluded Provider search on: <ol style="list-style-type: none"> OIG http://exclusions.oig.hhs.gov/ (conducted bi-monthly by CPNW) GSA http://www.sam.gov (conducted bi-monthly by CPNW) Washington State Patrol Background Check (WATCH) annually thereafter) Criminal History Disclosure (annual) and kept on file by education institution (If your school does not provide a disclosure form you can find one by clicking here) <p>LICENSE (If individual is licensed as any healthcare provider [RN, LPN, NAC, etc.] and in what specific State)</p> <ul style="list-style-type: none"> Current Unencumbered <p>INSURANCE</p> <ul style="list-style-type: none"> Professional Liability \$1,000,000/3,000,000 policy (This may be coverage via the school or individual) <p>CPR</p> <ul style="list-style-type: none"> You are required to complete an American Heart Association (AHA) BLS Provider Course and have a current Course card/eCard. AHA BLS Provider Resuscitation Quality Improvement Program (RDI) meets this requirement. <p>REQUIRED EDUCATION</p> <ul style="list-style-type: none"> Each healthcare organization will communicate to faculty and students any required educational content to be completed prior to participation in the clinical experience. The Clinical Passport is intended to follow a student through their academic program and therefore updated when any field expires and/or from year to year. There is no need to introduce or start a new Passport each academic year. |



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This is a digital PDF and should not be handwritten.
All dates should be submitted in the following format: mm/dd/yyyy

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| Student/Faculty Name: | Nursing Student | DOB: | 02/30/1992 |
| College: | Bellevue College | | |
| Program: | Nursing AAS-T | | |
| Form Verified By: | Name: | Date: | |
| | Name: | Date: | |
| | Name: | Date: | |
| | Name: | Date: | |

SUBMITTED ONCE

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| <input checked="" type="checkbox"/> | TUBERCULIN STATUS A. Two-step TST#1 Place Date: 01/06/2021 Read Date: 01/09/2021 Result 0 mm <input checked="" type="checkbox"/> Neg <input type="checkbox"/> Pos Two-step TST#2 Place Date: 01/20/2021 Read Date: 01/23/2021 Result 0 mm <input checked="" type="checkbox"/> Neg <input type="checkbox"/> Pos OR B. TB IGRA Date: Result: C. If New Positive TST or IGRA Exam/X-ray Date: OR D. History of Pos. TST or IGRA/Neg X-ray Date: |
| <input checked="" type="checkbox"/> | HEPATITIS B (3 primary series shots [at 0, 1, 6 months] plus titer confirmations 6-8 weeks later) A. Vaccination Dates 1. 02/30/1992 Titer: 2. 04/10/1992 Date drawn: 07/09/2019 3. 09/23/1992 Result: <input checked="" type="checkbox"/> Neg <input type="checkbox"/> Pos OR B. If negative titer after initial series of 3 vaccines, then vaccine #4 and re-titer OR #5 and #6 vaccines and re-titer 4. 08/02/2019 Titer: 5. 09/06/2019 Date drawn: 04/13/2020 6. 02/20/2020 Result: <input type="checkbox"/> Neg <input checked="" type="checkbox"/> Pos OR C. Immunity by titer (anti-HBs or HepB Sab) Date: D. Signed declination Date: E. History of disease Date: F. Medical immunity per military code <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | MMR (Measles, Mumps, Rubella) A. Vaccination Dates 1. 03/10/1993 2. 06/01/1993 OR B. Immunity by titers: Measles titer Date: 07/09/2019 Mumps titer Date: 07/09/2019 Rubella titer Date: 07/09/2019 C. Medical immunity per military code <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | VARICELLA (Chicken Pox) A. Vaccination Dates 1. 03/10/1993 2. 06/01/1993 OR Immunity by titer Date: B. Medical immunity per military code <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | TETANUS/DIPHTHERIA/PERTUSSIS (Tdap required after age 11) A. Tdap Date: 05/01/2004 B. Td Date: 07/29/2014 |
| <input type="checkbox"/> | AUTHORIZATION FOR RELEASE OF RECORD (School keeps this on file) |
| <input type="checkbox"/> | MILITARY IMMUNIZATION (medical immunity) • Exempt status for certain vaccines according to military code Click here... |
| <input type="checkbox"/> | ADDITIONAL REQUIREMENTS (If Applicable) The healthcare organization may have additional requirements that must be completed. Date: _____ Date: _____ Date: _____ |

SUBMITTED EVERY YEAR

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| <input type="checkbox"/> | TUBERCULIN STATUS A. Annual TST (given less than one year from previous TST) Place Date: Read Date: Result mm <input type="checkbox"/> Neg <input type="checkbox"/> Pos Place Date: Read Date: Result mm <input type="checkbox"/> Neg <input type="checkbox"/> Pos Place Date: Read Date: Result mm <input type="checkbox"/> Neg <input type="checkbox"/> 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: X-ray Date: D. For Known History of Positive/Possible Treatment: Complete Annual symptom check Date: |
| <input checked="" type="checkbox"/> | INFLUENZA (Effective Dates: 8/31/20XX-6/30/20XX) A. Healthcare administered seasonal vaccination Provider: Fake Hospital Date: 11/17/2020 Provider: Fake Hospital Date: 01/08/2020 Provider: Other Fake Hospital Date: 12/14/2018 B. Signed Declination Date: ; |
| <input type="checkbox"/> | 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 C. Washington State Patrol Check (WATCH) upon admission and then annually. Date: ; D. Criminal History Disclosure (School keeps this on file) Date: ; ; Need a Disclosure form? Click Here |
| <input type="checkbox"/> | LICENSE (Any <u>healthcare</u> license, registration) A. State: License# Expiration date: ; ; ; OR B. <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> | INSURANCE A. Professional Liability Policy Expiration Date: ; |
| <input type="checkbox"/> | AHA/BLS COURSE (Course must be American Heart Association (AHA) BLS provider.) A. Expiration Date: Date: |
| <input type="checkbox"/> | REQUIRED EDUCATION All students and faculty must complete ALL student learning modules on the CPNW website. Any questions, please consult your program. |