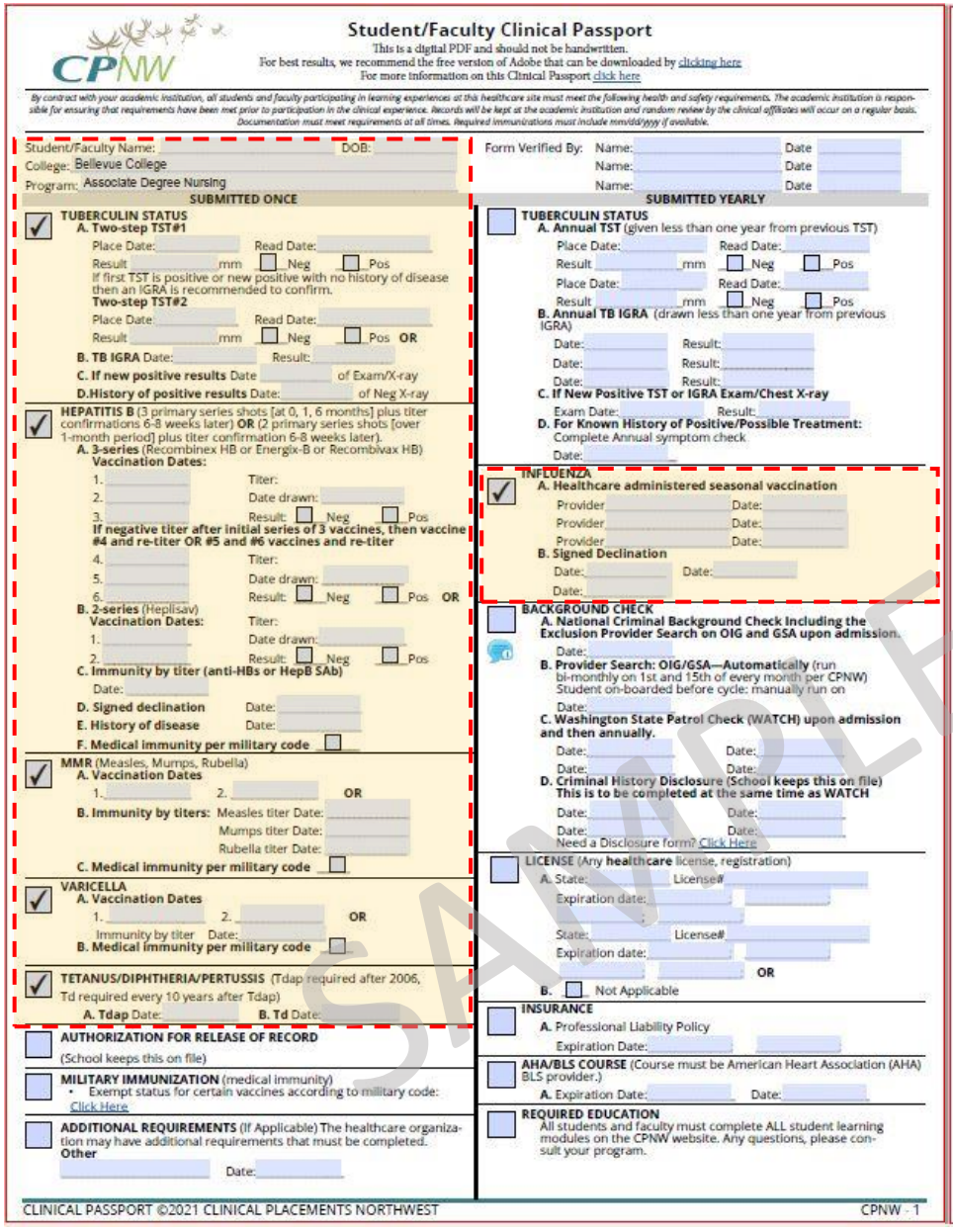
Sample Student/Faculty Clinical Passport Form

ATTENTION ADN APPLICANTS: The sections highlighted in yellow should be completed or nearly completed when applying to the ADN program. Instructions for completing remaining sections will be provided AFTER admittance.



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: Bellevue College
Program: Associate Degree Nursing

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 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: of Neg X-ray

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
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

MMR (Measles, Mumps, Rubella)
A. Vaccination Dates
1. 2. **OR**
B. Immunity by titers: Measles titer Date:
Mumps titer Date:
Rubella titer Date:
C. Medical immunity per military code

VARICELLA
A. Vaccination Dates
1. 2. **OR**
Immunity by titer Date:
B. Medical immunity per military code

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap required after 2006, Td required every 10 years after Tdap)
A. Tdap Date: **B. Td** Date:

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

MILITARY IMMUNIZATION (medical immunity)
- Exempt status for certain vaccines according to military code: Click Here

ADDITIONAL REQUIREMENTS (If Applicable) The healthcare organization may have additional requirements that must be completed.
Other
Date:

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
Date:

INFLUENZA
A. Healthcare administered seasonal vaccination
Provider Date:
Provider Date:
Provider Date:
B. Signed Declination
Date: Date:
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

LICENSE (Any **healthcare** license, registration)
A. State: License#
Expiration date:
State: License#
Expiration date:
OR
B. Not Applicable

INSURANCE
A. Professional Liability Policy
Expiration Date:

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

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

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SUBMITTED ONCE

COVID-19 Vaccination
A. Vaccine Information
Manufacturer:
Single or 2 dose series:
Date of first dose:
Date of second dose:
B. Signed Declination. Please note that not all facilities will accept declinations. Please see Site Requirements for details.
Exemption type: Medical Religious
Date:

SUBMITTED YEARLY

COVID-19 Vaccination
A. Vaccine Information
Manufacturer: Date of booster:
Manufacturer: Date of booster:
Manufacturer: Date of booster:
B. Signed Declination. Please note that not all facilities will accept declinations. Please see Site Requirements for details.
Exemption type: Medical Religious
Date: Date: Date: