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:____________________

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)

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:__________

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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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: __________