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:_____
Student Employment Facility: _____

Form Verified By: Name:_____ Date _____
Name:_____ Date _____
Name:_____ Date _____

SUBMITTED ONCE

☐ **TUBERCULIN (Tb)** Required upon admission to the program. If past or new positive, please see Clinical Passport Guidance document for further instructions. The Tuberculin requirement can be met through completion of one of the following:

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 and/or provider examination with Chest XRay is recommended to confirm.

Two-step TST#2

Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos **OR**

B. TB IGRA Date:_____ Result:_____

C. Past or new positive, history of BCG vaccine* Upload documen(s) of diagnostic and treatment progression (i.e. date of exam, secondary TST results, IGRA, chest xray, treatment, provider notes etc..)

Date:_____ (Self-Screening Tool)
TB Chest Xray Date:_____ ☐ Neg ☐ Pos

***Note: Individuals who have previously received the BCG vaccine may potentially show a false positive with Tuberculosis Skin Testing (TST). In these instances, it is encouraged that users complete a TB Interferon-Gamma Release Assay (IGRA) for more accurate results.**

☐ **HEPATITIS B** The Hepatitis B requirement can be met through completion of one of the following:

A. Proof of immunity (after 2 or 3 step series) by Titer (anit-HBs or HepB SAb are the ONLY accepted titers)

Date: _____ Result:_____

B. Signed Series in Process Form Date: _____

C. Non-converter/History of disease: Must provide series information if applicable.

☐ Yes

- **3-series** (Recombinex HB or Energix-B or Recombivax HB) Upload series information AND Healthcare Provider note confirming non-converter/history of disease. Healthcare Provider Note must outline that the user has completed 2 series types, with proper titers drawn, indicating ongoing Negative titer results.

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**

- **2-series** (Heplisav)

Vaccination Dates: Titer:

1. _____ Date drawn:_____
2. _____ Result: ☐ Neg ☐ Pos

If negative titer after initial series of 2 vaccines, then vaccine #3 and re-titer and #4 vaccines and re-titer

3. _____ Titer:
4. _____ Date drawn: _____
Result: ☐ Neg ☐ Pos

SUBMITTED YEARLY

☐ **TUBERCULIN (Tb)** All users must complete the Annual Tb Symptom Check form.

- Based on Tb Symptom Check results, users can identify if further Tb Status Test(s) are required.
- Self-Screening Tool

Completed and uploaded Annual Symptom Check form.

Date uploaded:_____

Complete the following section only if you answered 'yes' on the 'Self-Screening Tool' under the 'Annual TB Status Required' section or if your provider recommended further testing. Notify your academic coordinator and proceed according to provider recommendations.

A. 2-step TST

Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos
Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos

B. 1-step TST

Place Date:_____ Read Date:_____
Result _____mm ☐ Neg ☐ Pos

C. Annual TB IGRA

Date:_____ Result:_____

D. Past or new positive, history of BCG vaccine* Upload documen(s) of diagnostic and treatment progression (i.e. date of exam, secondary TST results, IGRA, chest xray, treatment, provider notes etc..)

Date:_____
TB Chest Xray Date:_____ ☐ Neg ☐ Pos

☐ **INFLUENZA** Include name of provider or location where the vaccination was received (CVS, Walmart, health dept., etc.), location address is NOT required.

A. Healthcare administered seasonal vaccination

Provider/Agency_____Date:_____
Provider/Agency_____Date:_____
Provider/Agency_____Date:_____

☐ **BACKGROUND CHECK**

A. National Criminal Background Check Including the Exclusion Provider Search on OIG and GSA upon admission.

Date:_____

B. Washington State Patrol Check (WATCH) upon admission and then annually.

Date:_____ Date:_____
Date:_____ Date:_____

C. Criminal History Disclosure *School keeps this on file

Date:_____ Date:_____
Date:_____ Date:_____
Need a Disclosure form? Click Here

D. 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:_____

☐ **AHA/BLS COURSE** (Course must be American Heart Association (AHA) BLS provider.)

A. Expiration Date:_____ Expiration Date:_____

☐ **INSURANCE:** Professional Liability policy in place.

☐ Insurance verified by program.
☐ Individual Insurance. If insurance is carried by the individual, upload certificate of current coverage to user account.
Individual Insurance Expiration Date:_____

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SUBMITTED ONCE

☐ **Measles, Mumps, and Rubella (MMR) or Measles, Mumps, Rubella, and Varicella (MMRV).** MMRV if received prior to the age of 12.

A. Vaccination Dates

1._____ 2. _____ **OR**

B. Immunity by titers: Measles titer Date: _____

Mumps titer Date: _____

Rubella titer Date: _____

☐ **VARICELLA**

A. Vaccination Dates

1. _____ 2. _____ **OR**

Immunity by titer Date: _____

☐ **TETANUS/DIPHTHERIA/PERTUSSIS (Tdap)** 1 dose of Tdap required followed by a dose of Td or Tdap every 10 years.

A. Initial Tdap Date: _____ **B. Td/Tdap** Date: _____

☐ **COVID-19 VACCINATION** Confirm with the Site Requirements on the CPNW website to determine specific COVID-19 vaccination requirments.

A. Vaccine Information

Manufacturer: _____ 1or 2 dose series: _____

Date of first dose: _____ Date of second dose: _____

☐ **RESPIRATOR DOCUMENTATION** *Verify with Academic/Program Coordinator for more information regarding this standard. This requirement is for high-risk students in direct patient care, such as nursing, respiratory therapy, MA's, Rad Tech's, and those in the Surgical Suite. For more details see tutorial. If directed by Program Coordinator complete the following:

A. Biennial Respiratory Medical Questionnaire complete?

☐ Yes, date completed: _____ ☐ No

B. Annual Respiratory Fit Test Record complete?

☐ Yes, date completed: _____ ☐ No

*Individual forms from different organizations are acceptable alternatives if the content is the same. Please ensure forms are uploaded to user's CPNW account.

- Respiratory Medical Questionnaire
- Respiratory Fit Test Record

☐ **MILITARY IMMUNIZATION Exempt** Status for certain vaccines according to military code are acceptable. Upload military exempt status paperwork to account users CPNW folder.

- Exempt status for certain vaccines according to military code:

☐ Hepatitis B ☐ MMR ☐ Varicella

☐ Other _____

Click Here

☐ **ADDITIONAL REQUIREMENTS** (If Applicable) The healthcare organization may have additional requirements that must be completed.

Other

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

SUBMITTED YEARLY

☐ **COVID-19 BOOSTER** Not all Healthcare facilities require annual boosters, confirm with the Site Requirements on the CPNW website. Healthcare Partners must report vaccination status for all employees, volunteers, and students. Therefore, users must submit all available COVID-19 vaccination information, even if it is not required for clinical access. This information is essential for mandatory reporting, and student participation is crucial.

A. Vaccine Information

Manufacturer: _____ Date: _____

Manufacturer: _____ Date: _____

Manufacturer: _____ Date: _____

☐ **RESPIRATOR DOCUMENTATION** *Verify with Academic/Program Coordinator for more information regarding this standard. This requirement is for high-risk students in direct patient care, such as nursing, respiratory therapy, MA's, Rad Tech's, and those in the Surgical Suite. For more details see tutorial. If directed by Program Coordinator complete the following:

A. Annual Respiratory Fit Test Record complete?

☐ Yes, date completed: _____ ☐ No

*Individual forms from different organizations are acceptable alternatives if the content is the same. Please ensure forms are uploaded to user's CPNW account.

- Respiratory Fit Test Record
- Respiratory Medical Questionnaire

☐ **LICENSE** (Any **healthcare** license, registration)

A. State:_____ License#_____

Expiration date:_____; _____;

_____; _____;

State:_____ License#_____

Expiration date:_____; _____;

_____; _____; **OR**

B. ☐ Not Applicable

☐ ***Office Use Only**

Pursued Exemptions:

Users must meet the health and safety requirements of the hosting facility. Inquiry for an exemption must be initiated through the educational institution.

Approved exemptions are to be uploaded to the individual's CPNW account.

Facility Name:_____ Date: _____

Exemption Type:_____

Facility Name:_____ Date: _____

Exemption Type:_____