Clinical Placements Northwest Student/Faculty Clinical Passport Requirements

Student/Faculty Name: Last, First, M.I. _____

_____

College: _____

Program: _____

These requirements are in place for the health and safety of students, faculty and their patients.

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 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

- Documentation of an initial 2-step TST is required AND documentation of an initial 2-step was completed
- 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 documentation 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

HEPATITIS B

- Documentation of 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 documentation 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)

MMR (Measles, Mumps, Rubella)

- 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

VARICELLA

- Proof of vaccination (2 doses administered at least 4 weeks apart) **OR**
- Proof of immunity by titer

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)

- Tdap **required** once "Tdap dose received after age 11 years"
- Td required every 10 years after Tdap

CPR

- American Heart Association (AHA) BLS Provider Card or Military Training Network (MTN) Provider Card only

AUTHORIZATION FOR RELEASE OF RECORD

- Kept on file by education institution

REQUIRED EDUCATION

- EACH HEALTHCARE ORGANIZATION WILL COMMUNICATE TO FACULTY AND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATION IN PATIENT CARE.

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

- 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.

INFLUENZA

- 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/

BACKGROUND CHECKS

- 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 RCW 43.43.830 and OIG and GSA screens. Excluded Provider search on:
  - OIG http://exclusions.oig.hhs.gov/ (conducted bimonthly by CPNW)
  - GSA http://www.sam.gov (conducted bi-monthly by CPNW)
- Washington State Patrol Background Check (WATCH annually thereafter)
- Disclosure Statement (annual) and kept on file by education institution

LICENSE (If individual is licensed as any healthcare provider [RN, LPN, NAC, etc.] and in what specific State)

- Current
- Unencumbered

INSURANCE

- Professional Liability $1,000,000/3,000,000 policy (This may be coverage via the school or individual)

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
- Food Handlers License

Students and Faculty will be informed prior to clinical experience if optional or additional requirements need to be met.

CPNW Clinical Placements Northwest

Clinical Placements Northwest Student/Faculty Clinical Passport Requirements

Student / Faculty Name: _____ DOB _____
College: _____
Program: _____
Form Verified by: _____
Name: _____ Date _____
Name: _____ Date _____
Name: _____ Date _____

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 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

A. Two-step TST#1 Place Date _____ Read Date _____
Result: mm _____ Neg _____ Pos _____
Two-step TST#2 Place Date _____ Read Date _____
Result: mm _____ Neg _____ Pos _____
B. TB IGRA Date _____ Result _____
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 months] plus titer confirmation (6-8 weeks later)

A. Vaccination Dates
1._____
2._____ Immunity confirmed by titer
3._____ Date _____ **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
1._____
2._____ Immunity confirmed by titer
3._____ Date _____ **OR**
C. Immunity confirmed by titer (anti-HBs or HepB SAb) DATE _____
D. Signed declination DATE _____
E. History of disease DATE _____ Known non-responder

MMR (Measles, Mumps, Rubella)

A. Vaccination Dates
1._____ 2. _____ **OR**
B. Immunity by titers: Measles Titer DATE _____
Mumps Titer DATE _____ Rubella Titer DATE _____

VARICELLA (Chicken Pox)

A. Vaccination Dates
1._____ 2. _____ **OR**
B. Immunity by titer DATE _____

TETANUS/DIPHTHERIA/PERTUSSIS

A. Tdap DATE _____ "Tdap dose after age 11 years"
B. Td DATE _____

AHA BLS Course (Course must be American Heart Association (AHA) BLS Provider or Military Training Network (MTN) Course.)

Expiration DATE _____

Authorization for Release of Record (School keeps this on file)

REQUIRED EDUCATION

EACH HEALTHCARE ORGANIZATION WILL COMMUNICATE TO FACULTY AND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATION IN PATIENT CARE.

ALL STUDENTS AND FACULTY WITHIN CLINICAL PLACEMENTS NORTHWEST MUST COMPLETE ALL STUDENT LEARNING MODULES ON THE CPNW WEB. ANY QUESTIONS, PLEASE CONSULT YOUR PROGRAM.

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

A. Annual TST (given less than one year from previous TST)
DATE _____ Result Neg _____ Pos _____ mm _____
DATE _____ Result Neg _____ Pos _____ mm _____
DATE _____ Result Neg _____ Pos _____ mm _____
B. Annual TB IGRA (drawn less than one year from previous IGRA)
DATE _____ Result _____ DATE _____ Result _____
DATE _____ Result _____
C. If New Positive/Exam/Chest X-ray
EXAM DATE_____ X-ray DATE _____
D. For Known Positive/Possible Treatment → Complete Annual Symptom Check Form.
DATE_____

INFLUENZA (Effective dates: 08/31/2018—06/30/2019)

A. Which healthcare provider administered vaccine? _____
B. Proof of seasonal vaccination DATE _____
DATE _____ DATE _____ DATE _____
C. Signed declination 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—**run bi-monthly on 1st and 15th of every month per CPNW**
DATE _____; _____; _____; _____; _____
C. Washington State Patrol Check (WATCH) upon admission and then annually
DATE _____; _____; _____; _____; _____
D. Disclosure Statement annually (School keeps this on file)
DATE _____; _____; _____; _____; _____

LICENSE (Any healthcare license, registration)

A. State _____ License # _____ Expiration Date _____ **OR**
B. Not Applicable

INSURANCE

A. Professional Liability Policy
Expiration DATE _____; _____

ADDITIONAL REQUIREMENTS (if applicable)

A. Vehicle Insurance DATE _____
B. Personal Health Insurance DATE _____
C. Drug Screening 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 _____
I. Food Handlers License DATE _____

This is not a comprehensive list; there may be more items.

CPNW Clinical Placements Northwest