

# 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

## SUBMITTED EVERY YEAR

**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

- \_\_\_\_\_
- \_\_\_\_\_ Immunity confirmed by titer
- \_\_\_\_\_ 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

- \_\_\_\_\_
- \_\_\_\_\_ Immunity confirmed by titer
- \_\_\_\_\_ 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

- \_\_\_\_\_ 2. \_\_\_\_\_ OR

B. Immunity by titers: Measles Titer DATE \_\_\_\_\_  
 Mumps Titer DATE \_\_\_\_\_ Rubella Titer DATE \_\_\_\_\_

**VARICELLA** (Chicken Pox)

A. Vaccination Dates

- \_\_\_\_\_ 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.

**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.*