



# 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](#)  
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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: \_\_\_\_\_ Form Verified By: Name: \_\_\_\_\_ Date \_\_\_\_\_  
 College: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_  
 Program: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_  
 Student Employment Facility: \_\_\_\_\_

### SUBMITTED ONCE

**TUBERCULIN STATUS** 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 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. New positive**, date of exam/chest xray: \_\_\_\_\_

**D. History of positive results** Date: \_\_\_\_\_ ([Self Screening](#))

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

**A. 3-series** (Recombinex HB or Energix-B or Recombivax HB) Series shots at 0, 1, 6 months plus titer confirmations 6-8 weeks later.

**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:**

1. \_\_\_\_\_ Titer: \_\_\_\_\_

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

**C. Immunity by titer (anti-HBs or HepB SAb)**

Date: \_\_\_\_\_

**D. Non-converter:** Must provide series information above.

\_\_\_\_ Yes

**E. Signed Series in Process Form** Date: \_\_\_\_\_

**MMR** (Measles, Mumps, Rubella) **OR** **MMRV** (Measles, Mumps, Rubella, Varicella). 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** 1 dose of Tdap required followed by a dose of Td or Tdap every 10 years.

**A. Initial Tdap** Date: \_\_\_\_\_ **B. Td/Tdap** Date: \_\_\_\_\_

### SUBMITTED YEARLY

**TUBERCULIN STATUS** Annual Tuberculin Status must be given less than one year from the administration date. Annual TST requirement may be met through completion of one of the following:

**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

Place Date: \_\_\_\_\_ Read Date: \_\_\_\_\_

Result \_\_\_\_\_ mm \_\_\_\_\_ Neg \_\_\_\_\_ Pos

Place Date: \_\_\_\_\_ Read Date: \_\_\_\_\_

Result \_\_\_\_\_ mm \_\_\_\_\_ Neg \_\_\_\_\_ Pos

**C. Annual TB IGRA**

Date: \_\_\_\_\_ Result: \_\_\_\_\_

Date: \_\_\_\_\_ Result: \_\_\_\_\_

Date: \_\_\_\_\_ Result: \_\_\_\_\_

**D. If New Positive TST or IGRA Exam/Chest X-ray**

Date of exam/chest xray: \_\_\_\_\_

Complete annual symptom check form. Date: \_\_\_\_\_

**E. For Known History of Positive/Possible Treatment:**

Complete Annual Symptom Check form: ([Self Screening](#))

Date of exam/chest xray: \_\_\_\_\_

**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) This is to be completed at the same time as WATCH, annually.**

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

**A. Professional Liability Policy**

Expiration Date: \_\_\_\_\_ ; \_\_\_\_\_ ;



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## SUBMITTED ONCE

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

### A. Vaccine Information

Manufacturer: \_\_\_\_\_ 1 or 2 dose series: \_\_\_\_\_

Date of first dose: \_\_\_\_\_ Date of second dose: \_\_\_\_\_

**RESPIRATOR DOCUMENTATION** \*Verify with Academic/Program Coordinator for more information regarding this standard. 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](#)

## AUTHORIZATION FOR RELEASE OF RECORD

(School keeps this on file)

**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

[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 and/or VACCINATION** Not all Healthcare facilities require annual boosters, confirm with the Site Requirements on the CPNW website. It is requested to include Booster information if available, even if not required.

### A. Vaccine Information

Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_

Manufacturer: \_\_\_\_\_ Date: \_\_\_\_\_

**RESPIRATOR DOCUMENTATION** \*Verify with Academic/Program Coordinator for more information regarding this standard. 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

## REQUIRED EDUCATION

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

## 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: \_\_\_\_\_

