



# 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: \_\_\_\_\_ Form Verified By: Name: \_\_\_\_\_ Date \_\_\_\_\_  
College: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_  
Program: \_\_\_\_\_ 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:

- \_\_\_\_\_ Titer: \_\_\_\_\_
  - \_\_\_\_\_ Date drawn: \_\_\_\_\_
  - \_\_\_\_\_ 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**
- \_\_\_\_\_ Titer: \_\_\_\_\_
  - \_\_\_\_\_ Date drawn: \_\_\_\_\_
  - \_\_\_\_\_ Result: \_\_\_\_\_Neg \_\_\_\_\_Pos **OR**

**B. 2-series** (HepLisav)  
**Vaccination Dates:**

- \_\_\_\_\_ Titer: \_\_\_\_\_
- \_\_\_\_\_ Date drawn: \_\_\_\_\_
- \_\_\_\_\_ 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

- \_\_\_\_\_
- \_\_\_\_\_ **OR**

**B. Immunity by titers:** Measles titer Date: \_\_\_\_\_

Mumps titer Date: \_\_\_\_\_

Rubella titer Date: \_\_\_\_\_

**C. Medical immunity per military code** \_\_\_\_\_

**VARICELLA**

##### A. Vaccination Dates

- \_\_\_\_\_
- \_\_\_\_\_ **OR**

Immunity by titer Date: \_\_\_\_\_

**B. Medical immunity per military code** \_\_\_\_\_

**TETANUS/DIPHtheria/PERTUSSIS** (Tdap required after 2006,

Td required every 10 years after Tdap)

**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: \_\_\_\_\_

### 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.



# 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.*

## SUBMITTED ONCE

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

