# Nursing Clinical Placement District #1
## Student Clinical Passport

By contract with your academic institution, all students participating in patient care in this healthcare institution must meet the following health and safety requirements. The academic institution is responsible for ensuring 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 healthcare institutions will occur on a regular basis. All documentation must meet requirements at all times during clinical course. Required immunizations must include mm/dd/yyyy if available.

<table>
<thead>
<tr>
<th>SUBMITTED ONCE</th>
<th>SUBMITTED EVERY YEAR</th>
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<td>Circle the applicable letter in each box.</td>
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### TUBERCULIN STATUS
- **A.** Two-step TST
  - 1) Skin Test #1 Date: __________ Result: __________
  - 2) Skin Test #2 Date: __________ Result: __________
  - OR
  - B. QuantIFERON (QFT) Date: __________ Result: __________
  - OR
  - C. If New Positive/Exam/X-ray Date: __________
  - OR
  - D. Positive TB/Negative X-ray Date: __________

### Hepatitis B
- (3 primary series shots: (at 0,1,6 mo) + Hep B surface antibody titer confirmation (6-8 weeks after completion of vaccine series)
  - A. Vaccination Dates
    - 1) __________
    - 2) __________
    - 3) __________
    - 4) Immunity confirmed by titer Date: __________
  - OR
  - B. Immunity by titer (anti-HBs) Date: __________
  - OR
  - C. Signed waiver Date: __________
  - D. Had the disease Date: __________
  - E. antiHbc Date: __________ Result: __________ Infectious is +, (you could be a carrier)

### MMR (Measles, Mumps, Rubella)
- A. Vaccination Dates
  - 1) __________
  - 2) __________
  - OR
  - B. Immunity by titers Date: __________

### Varicella (Chicken Pox)
- A. Vaccination Dates
  - 1) __________
  - 2) __________
  - OR
  - B. Immunity by titer Date: __________

### Tetanus/Diphtheria (primary series of three)
- Date Completed: __________
  - A. Booster within the last 10 years: Date: __________
  - If booster after 2004, was this a Tdap (please find out) Yes or No: __________
  - B. If no, Tdap required once Date: __________

### CPR Health Care Provider Level (adult, infant, child, AED)
- Expiration Date: __________

### Fire Safety Module
- Date Completed: __________

### HIPAA Privacy Training
- Date Completed: __________

### Bloodborne Pathogens Training
- Date Completed: __________

### Background Check (including Disclosure Statement)
- A. National Criminal Background Check Dates: __________, __________ AND
  - B. Washington State Patrol Check Dates: __________, __________ AND
  - C. Excluded Provider Search on OIG and GSA Dates: __________, __________

### Influenza
- A. Proof of annual vaccination
  - Date 1: __________
  - 2: __________
  - 3: __________
  - OR
  - B. Signed waiver Date: __________

### License (RNs, LPNs, CNAs)
- A. WA State Date: __________
  - B. Not Applicable

### Insurance
- A. Professional Liability Policy Date: __________

### OPTIONAL REQUIREMENTS (if applicable)
- A. Vehicle Insurance Date: __________
- B. Personal Health Insurance Date: __________
- C. Drug Screen 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. Code of Conduct Date: __________
- I. Color Vision Test Date: __________

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

2012-2-21