TCPS℠ ORIENTPRO

Student/Faculty Clinical Passport Version 1

STUDENT/FACULTY INFORMATION

NAME: _____ _____
LAST FIRST

SCHOOL: _____

☐ **I am ≥ 18 years old.**

If under 18, enter birthdate ___/_____/_____

HEALTHCARE INSURANCE:
□ YES, Provider: _____
□ No

PHYSICAL EXAM DATE (clearing for clinical placement): _____

NEGATIVE CRIMINAL BACKGROUND CHECK:
Date: _____ Verified by: _____

INSTRUCTOR/ARRN LICENSURE VERIFICATION*:
RENEWAL # _____

EXPIRATION DATE: _____

CERTIFICATIONS/SPECIALTY:
_____

NEGATIVE DRUG SCREEN (if available or required):

Date: _____ Verified by: _____

***Only if required by the facility!**

HEALTH RECORD

MEASLES, MUMPS, & RUBELLA
Dates of Vaccine:
MMR #1: _____ MMR #2:_____
Date of positive titers if required:
Measles titer: _____
Mumps titer: _____
Rubella titer: _____

INFLUENZA (Annual requirement)

Year 1 Date of Vaccine: _____

Year 2 Date of Vaccine: _____

-OR- ☐ Signed Medical Waiver on File

HEPATITIS B (2 or 3-step vaccine):
Dates of Vaccine:
HB#1:_____ HB#2:_____ HB#3: _____
-OR-
Date of Disease: _____
Date Immunity confirmed by titer: _____

-OR- ☐ Signed Medical Waiver on File

TETANUS/DIPTHERIA/PERTUSIS (10-year expiration)
(Adult Tdap–not DTaP or Td unless allergy is documented)
Date of Vaccine: _____

Date of Td vaccine: _____

☐ Signed Medical Waiver on File

VARICELLA (CHICKEN POX)
Dates of Vaccine: #1: _____ #2: _____

Date of positive varicella titer: _____

COVID-19 (if required)
Date of most recent negative test: _____
Vaccine: ☐ J&J ☐ Moderna ☐ Pfizer
☐ Other _____
Dose 1 Date: _____ Dose 2 Date: _____
Booster Dates(s): _____ _____
☐ Signed Medical Waiver on File

HEALTH RECORD

TB SCREENING (as required) Enter the date(s) based upon the type of screening that was done!

Dates of Negative Baseline 2-Step TB Test: #1__________ #2 _________

Date of Negative TB Skin Test: Year #1____________ Year #2 _______________

Date of Negative TB Blood (IGRA) (QFT-Gold or T.Spot-TB) Test:
Year #1_______ Year #2 ________

Date of Negative TB Screening Questionnaire: Year #1 ___________ Year #2 _______________

Less Common ~~~~~~

Date of BCG Vaccine: ___________

Date of Negative TB Chest Xray: ___________ Date of TB History: ______________

CPR

Students/Faculty must have a current card/roster indicating Healthcare Provider status to participate in clinical!

Expiration Date: _______________ American Heart Association – or - American Red Cross*

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* Note that many facilities will only recognize American Heart Association Healthcare Provider CPR. Check with your faculty prior to taking any CPR course outside of your school.

GENERAL HEALTHCARE ORIENTATION

Complete this content once per academic year!

GENERAL ORIENTATION QUIZ - the Completion Certificate should be kept with the Clinical Passport!	Date: ___________ Score: ___________ Date: ___________ Score: ___________

CLINICAL FACILITIES SPECIFIC ORIENTATION

Be sure and include any required facility documentation including Quiz Certificates with your Passport!

Facility: ____________________ Date: _________	Facility: ___________________ Date: _________

VERIFICATION OF ACCURATE DOCUMENTATION (SIGNATURE of INSTRUCTOR & DATE)

SIGNATURE: _____________________________ DATE _________________________________

SIGNATURE: ______________________________ DATE _________________________________

SIGNATURE: ______________________________ DATE _________________________________

SIGNATURE: ______________________________ DATE ________________________________

Note: This Clinical Passport may be used for 2 consecutive years based on your program of study.