

## **Student/Faculty Clinical Passport Version 1 AY2020-2021**

STUDENT/FACULTY INFORMATION			
NAME: LAST FIRST	SCHOOL:		
<b>DATE OF BIRTH:</b> /	HEALTHCARE INSURANCE:  □ YES, Provider: □ No		
CRIMINAL BACKGROUND CHECK:  Date: Verified by:	INSTRUCTOR LICENSURE VERIFICATION*:  RENEWAL # EXPIRATION DATE:		
DRUG SCREEN (if available or required):  Date: Verified by:	**Only if required by the facility!		
HEALTH RECORD  MEASLES, MUMPS, & RUBELLA  Born before 1957			
Dates of Vaccine: MMR #1: MMR #2:  Date drawn and result of: Measles titer: Result: R			
TUBERCULIN SKIN TEST (PPD) (potential annual requirement)  Chest x-ray if positive PPD Date: Result:  Date: Result:  Medical Screening Report Date: Result:			
HEPATITIS B  ☐ Dates of Vaccine: HB#1: HB#2:  ☐ Date of Disease:  ☐ Immunity confirmed by blood titer HbsAB: Date:	Date of Vaccination:		
☐ Hepatitis B declination waiver signed: Date:  VARICELLA (CHICKEN POX)  ☐ Date and result of varicella titer:  Dates of vaccination: #1: #2:	TETANUS/DIPTHERIA/PERTUSIS (Tdap–not DTaP or Td)  Date of Vaccination:		

Students/Facult	y must have a current card/roster	CPR indicating Healthcare Provi	ider status to participate in clinical!	
Expiration	Date: Americ	American Heart Association – or - American Red Cross*		
Expiration 1	Date: America	American Heart Association – or - American Red Cross*		
* 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 ONLINE HEALTHCARE ORIENTATION  Complete this content once per academic year!				
	<b>FATION QUIZ -</b> the Completion 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:	
Facility:	Date:	Facility:	Date:	
Facility:	Date:	Facility:	Date:	
Facility:	Date:	Facility:	Date:	
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VERIFICATION OF ACCURATE DOCUMENTATION (SIGNATURE of INSTRUCTOR & DATE)         DATE				
DAIL	<del>-</del>	SIGNATURE.		
DATE		SIGNATURE: _		
DATE		SIGNATURE: _		
DATE		SIGNATURE: _		

Note: This Clinical Passport may be used for 2 consecutive years based upon your program of study. 6/2020