Student/Faculty Clinical Passport Version 2 AY2020-2021

STUDENT/FACULTY INFORMATION	
NAME: _____ _____ **LAST** **FIRST**	**SCHOOL:** _____
DATE OF BIRTH: ____/_____/_____	**HEALTHCARE INSURANCE:** ☐ YES, Provider: _____ ☐ No
CRIMINAL BACKGROUND CHECK: Date: _____ Verified by: _____	**INSTRUCTOR LICENSURE VERIFICATION*:** RENEWAL # _____ EXPIRATION DATE: _____ CERTIFICATIONS/SPECIALTY: _____ ***Only if required by the facility!**
DRUG SCREEN (if available or required): **Date: _____ Verified by: _____**	

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*

* 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!

GENERAL ORIENTATION QUIZ - the Completion Certificate should be kept with the Clinical Passport!	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: _____

VERIFICATION OF ACCURATE DOCUMENTATION (SIGNATURE of INSTRUCTOR & DATE)

DATE _____ SIGNATURE: _____

DATE _____ SIGNATURE: _____

DATE _____ SIGNATURE: _____