Non-Clinical Healthcare Passport Version 3

STUDENT/FACULTY INFORMATION

NAME: _____ _____
LAST **FIRST**

SCHOOL: _____

☐ I am ≥ 18 years old.

If under 18, enter birthdate ___/_____/_____

HEALTHCARE INSURANCE:
☐ YES, Provider: _____
☐ No

CRIMINAL BACKGROUND CHECK:

Date: _____ Verified by: _____

INSTRUCTOR/APRN LICENSURE VERIFICATION*:

RENEWAL # _____ EXPIRATION DATE: _____

CERTIFICATIONS/SPECIALTY: _____

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

DRUG SCREEN (if available or required):

Date: _____ Verified by: _____

COVID-19 (if required)

Date of most recent negative test: _____

Vaccine: ☐ J&J ☐ Moderna ☐ Pfizer Dose 1 Date: _____ Dose 2 Date: _____

☐ Other: _____

Booster Dates(s): _____ _____ ☐ Signed Medical Waiver on File

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: _____