NORTH SEATTLE COLLEGE
One of the Seattle Colleges

Initial Compliance Form

	Education Module Checklist **All completed forms and certificates must be uploaded to your Complio account (NOTE: This list contains active links to education modules)**
☐	1. **OSHA General Industry: Bloodborne Pathogens Certificate of Completion** Follow the link, create an account if needed, and complete the training ($14.95). Print out certificate of completion and upload to Complio.
☐	2. **HIV Training Certificate of Completion** 7 Hour HIV Training: Review material. You will be tested during 1st quarter nursing class, date TBD, certificate will be awarded by instructor. Prior certificate can be used with approval of nursing faculty. Upload certificate to Complio.
☐	3. **HIPAA Certificate of Completion** HIPAA training will be completed and certificate awarded during 1st quarter nursing classes or prior certificate may be used with approval of nursing faculty. Upload certificate to Complio.
☐	4. **OSHA General Industry: Hazard Communications Certificate of Completion** Follow the link, create an account if needed, and complete training ($14.95). Print certificate and upload to Complio.
☐	5. **Workplace Violence Certificate of Completion** Follow the link, create an account if needed, go to Course Catalog, choose Online Courses and select "Violence in the Workplace" training (free). Print certificate and upload to Complio account.
☐	6. **Ergonomics & Injury Prevention Certificate of Completion** Follow the link and read the material: Ergonomics Training. Print, fill out, and sign Ergonomics Certificate located on next page of this document, and upload to Complio.

Clinical Placements Northwest Collaborative Student/Faculty Clinical Passport Requirements

Student/Faculty Name: Last, First, M.I.

College:
Program:

These requirements are in place for the health and safety of students, faculty and their patients.

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that 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 clinical affiliates will occur on a regular basis. *Documentation must meet requirements at all times.* Required immunizations must include mm/dd/yyyy if available.

SUBMITTED ONCE

TUBERCULIN STATUS

- If no previous records or more than 12 months since last TST → 2 step TST **OR**
- TB IGRA test within 12 months **OR**
- If negative TST within 12 months → one step TST **OR**
- If newly positive TST → F/U by healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and need to complete health questionnaire
- If history of positive TST → provide documentation of TST reading, provide proof of chest X-ray documenting absence of M. TB, medical treatment and negative symptom check **OR**
- If history of BCG vaccine → TB IGRA. If negative → OK; If positive → do Chest X-Ray

HEPATITIS B

- Series of 3 vaccines completed at appropriate time intervals and post vaccination titer at 6-8 weeks after series completion
- If negative titer, then repeat series (consisting of doses 4-6) and repeat titer 6-8 weeks after #6 dose. **OR**
- Provide documentation of positive titer (anti-HBs or HepB SAb) **OR**
- **IF** post vaccination titer is not completed 6-8 weeks after series completion - repeat Series of 3 vaccines (doses #4 - #6) & obtain post vaccination titer at 6-8 weeks after series #2 completed.
- Signed declination for students/faculty who decline vaccination *Specific healthcare institutions may require vaccination without exception (i.e., no declination)*

MMR (Measles, Mumps, Rubella)

- Proof of immunity by titer **OR**
- Proof of vaccination (2 doses at appropriate intervals)

VARICELLA (Chicken Pox)

- Proof of immunity by titer **OR**
- Proof of vaccination (2 doses at appropriate intervals)

TETANUS, DIPTHERIA, PERTUSSIS (Tdap)

- Tdap **required** once
- Td required every 10 years after Tdap

CPR

- American Heart Association BLS Healthcare Provider Certificate

AUTHORIZATION FOR RELEASE OF RECORD kept on file w/program

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTY AND STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN CLINICAL PLACEMENT CONSORTIUM # 1(CPC1) AND INLAND NORTHWEST CLINICAL PLACEMENT (INCPC) CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR PROGRAM.

SUBMITTED EVERY YEAR

TUBERCULIN STATUS

- Annual TST **OR**
- Annual TB IGRA test **OR**
- If newly positive TST results→ F/U with healthcare provider (chest X-ray, symptoms check and possible treatment documentation of absence of active M. TB disease) and may need to complete health questionnaire.
- Previously documented +TST results and prior negative chest X-ray results: submit annual symptom check completed within one year from healthcare provider

INFLUENZA

- Proof of seasonal vaccination(s) **OR**
- Signed declination for student/faculty who decline vaccination

  Specific healthcare institutions may require vaccination without exception (i.e., no declination) http://flushot.healthmap.org/

BACKGROUND CHECKS

- National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/readmission and reentry/hire to program to include all counties of residence & all Washington State counties per RCW 43.43.830 and OIG and GSA screens. Excluded provider search on:
  - OIG http://exclusions.oig.hhs.gov/
  - GSA http://www.sam.gov
- Washington State Patrol Background Check (WATCH) annually thereafter

LICENSE (if faculty licensed or certified as any healthcare provider (RN, LPN, NAC, etc. & in what specific State)

- Current
- Unencumbered

INSURANCE

- Professional Liability $1,000,000/3,000,000 policy (This may be coverage via the school or individual)

ADDITIONAL REQUIREMENTS (if applicable)

Some healthcare settings may have additional requirements, such as the following:

- Vehicle Insurance (for access to VA & Military Facilities)
- Personal Health Insurance
- Drug Screen
- Hepatitis A Vaccine
- Current First Aid Card
- Proof of U.S. Citizenship
- Color Vision Test
- Food Handlers License

Students and Faculty will be informed prior to clinical experience if optional or additional requirements need to be met.

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Clinical Placements Northwest Collaborative Student/Faculty Clinical Passport Requirements

Student/Faculty Name
Last Name, First, M.I. ______________________ **DOB**

College: ______________________

Program: ______________________

Form verified by: ______________________

Name ______________________ Date ______________________

Name ______________________ Date ______________________

Name ______________________ Date ______________________

By contract with your academic institution, all students and faculty participating in patient care experiences must meet the following health and safety requirements. The academic institution is responsible for ensuring that 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 clinical affiliates will occur on a regular basis. *Documentation must meet requirements at all times.* Required immunizations must include mm/dd/yyyy if available.

SUBMITTED ONCE

☐ **TUBERCULIN STATUS**

A. Two-step TST 1) Skin Test #1Date_________Result: Neg____Pos____mm_____
2)Skin Test #2 Date_________Result: Neg____Pos____mm_____
(#2 Placed within 1-3 weeks of #1) **OR**

B. TB IGRA Date_______ Result:_________
OR

C. If New Positive/Exam/X-ray Date________
OR

D. Positive TST/Negative X-ray Date________

☐ **HEPATITIS B** (3 primary series shots: (at 0,1,6 mo) plus titer confirmation (6-8 weeks later)

A. Vaccination Dates
1) ______________
2) ______________
3) ______________
Immunity confirmed by titer Date _______ **OR**

B. If negative titer after initial series of 3 vaccines, then vaccines #4-#6
4) ______________
5) ______________
6) ______________
Immunity confirmed by titer Date _______

C. Immunity confirmed by titer (anti-HBs or HepB SAb) Date_______ **OR**

D. Signed declination Date __________

E. History of disease Date__________Known non responder________

☐ **MMR** (Measles, Mumps, Rubella)

A. Immunity by titers: Measles Date_____________
Mumps Date____________ Rubella Date_____________ **OR**

B. Vaccination Dates
1)___________ 2) _____________

☐ **VARICELLA** (Chicken Pox)

A. Immunity by titer Date______________ **OR**

B. Vaccination Dates
1) _________ 2)_________

☐ **TETANUS/DIPTHERIA/PERTUSSIS**

A. Tdap Date ___________

B. Td Date___________

☐ **AHA BLS Healthcare Provider Certificate**

Expiration Date __________

☐ **Authorization for Release of Record**

School keeps this on file

REQUIRED EDUCATION

EACH HEALTHCARE INSTITUTION WILL COMMUNICATE TO FACULTY AND TO STUDENTS ANY REQUIRED EDUCATIONAL CONTENT TO BE COMPLETED PRIOR TO PARTICIPATING IN PATIENT CARE.

STUDENTS AND FACULTY IN CPC#1 AND INCPC CONSORTIUMS WILL ACCESS STUDENT LEARNING MODULES ONLINE. PLEASE REFER TO PASSPORT COVER LETTER FOR INFORMATION. IF ANY QUESTIONS, PLEASE CONSULT YOUR PROGRAM.

SUBMITTED EVERY YEAR

☐ **TUBERCULIN STATUS**

A. Annual TST (given less than one year from previous TST)
Date_________ Result: Neg____Pos____mm______
Date_________ Result: Neg____Pos____mm______
Date_________ Result: Neg____Pos____mm______ **OR**

B. Annual TB IGRA (drawn less than one year from previous IGRA)
Date__________Result:______Date_______Result:_____
Date__________Result:_______ **OR**

C. If New Positive/Exam/Chest X-ray
Exam Date________ X-ray Date_______ **OR**

D. Known Positive/Possible Treatment/ Annual Symptom Check from Health Care Provider Date___________

☐ **INFLUENZA** **Effective dates: 08/31/2015 – 4/30/2016**

A. Which healthcare provider administered vaccine?

B. Proof of seasonal vaccination
Date 1_______Date 2_________ Date 3________ **OR**

C. Signed declination
Date 1_______Date 2_________ Date 3________

☐ **BACKGROUND CHECK**

A. National Criminal Background Check including Excluded Provider Search on OIG and GSA upon admission
Date_____________

B. Washington State Patrol Check (WATCH) upon admission and annually
Dates_________,________,_________,_________

C. Disclosure Statement
Dates_________,________,_________,_________

☐ **LICENSE** (**Any healthcare license, certification, registration)**

A. State_____ #_____________________Exp. Date__________
OR

B. Not Applicable

☐ **INSURANCE**

A. Professional Liability Policy Date: _______

☐ **ADDITIONAL 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. Color Vision Test Date ___________
I. Food Handlers License Date ___________

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

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