REGIONAL NURSING CLINICAL PLACEMENT FACULTY PASSPORT

Faculty must carry this passport with them while in the clinical setting

NAME: Last: _____ First: _____M.I.____ Faculty ID #: _____
(Print) (Print)

College: _____
(Print)

1. CPR (AHA Healthcare Provider) bi-annual requirement:
   Date: _____ Date: _____ Date: _____ Date: _____

2. RN license verified by: _____Date of verification: _____

3. Clinical competency: Highest Degree Earned: _____

4. Practice Specialty: _____ Clinical Certifications: _____

5. Urine Drug Testing date verified: _____

6. Criminal Background Check date verified: _____ Type: _____
   (Federal, State, County)

7. Fraud & Abuse Detection and Prevention (federal law 2007) Education verified:
   Date: _____

8. HIPAA Education, Fire Safety, Blood borne Pathogens, Infection Control, Hazardous Chemicals (annual requirement):

Date:	Facility:	Date:	Facility:
Date:	Facility:	Date:	Facility:
Date:	Facility:	Date:	Facility:

Immunizations Verification:

9. Tuberculosis Testing (annual requirement):
   Date: _____ Date: _____ Date: _____ Date: _____

10. Hepatitis B, Varicella (chicken pox), Mumps, Rubella, Rubeola, Diphtheria/Tetanus verified:
    Date: _____

Verification of Accurate Documentation (program director signature & date):

First Year:		**Second Year:**	
Fall:	Date:	Fall:	Date:
Winter:	Date:	Winter:	Date:
Spring:	Date:	Spring:	Date:
Summer:	Date:	Summer:	Date:
Third Year:		**Fourth Year:**	
Fall:	Date:	Fall:	Date:
Winter:	Date:	Winter:	Date:
Spring:	Date:	Spring:	Date:
Summer:	Date:	Summer:	Date:

Name Dean of School of Nursing or Designee_____Signature_____
(Please Print)

Rev: 02/21/08