

# Kadlec Passport Instructions

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

\*\* If participant is a current employee, extern, or volunteer, all vaccinations, TB tests, and if necessary follow-up chest x-ray (for positive TB tests) can be obtained through employee health as part of the employee health benefit program. Please contact employee health for more information.

## INITIAL REQUIREMENTS

## ANNUAL REQUIREMENTS

### Tuberculin Status

\*\*Initial TB test must be completed within 1 year prior to clinical start date.

- A. Documentation of two step PPD (skin test) with a negative result **OR**  
 B. Documentation of an IGRA (blood test) with a negative result

\*\*If first time positive PPD or IGRA, follow up with a healthcare provider to obtain a medical clearance letter to include chest x-ray results.

**OR**

\*\*If chronic (>2) positive PPD or IGRA, provide documentation of two separate PPD or IGRA test readings, proof of chest x-ray documenting absence of TB, proof of medical treatment (if applicable), and TB questionnaire.

### Tuberculin Status

A. If first time positive result on previous test, repeat initial requirements. **OR**

B. If chronic (>2) positive, a Tuberculosis Screening Questionnaire must be filled out. (Pick up in Education office)

### Influenza

A. Proof of seasonal vaccination(s) **OR**

B. Signed declination for participants who decline vaccination. Individuals who sign declination will be required to wear a mask during active flu season.

### Background Check

A. Initial only: National Criminal Background Check including Excluded Provider Search on OIG and GSA must be completed prior to clinical start date. Background checks completed upon admission to an educational institution for which the clinical rotation will take place will also be accepted. Background checks completed upon hire at Kadlec will also be accepted.

**AND**

B. Washington State Patrol Check (WATCH) form must be completed and submitted to the Education office prior to clinical start date then each year thereafter until the conclusion of clinical experience at Kadlec

**AND**

C. Criminal Disclosure Statement form must be completed and submitted to the Education office prior to clinical start date then each year thereafter until the conclusion of clinical experience at Kadlec

### Hepatitis B

- A. Documentation of series of 3 vaccines completed at appropriate time intervals and post vaccination titer at 6-8 weeks after series completion.  
 B. If negative titer showing no immunity after initial series, obtain vaccination #4 and re-titer after 6-8 weeks or obtain vaccination #4-#6 and re-titer after 6-8 weeks. Please see your healthcare provider for recommendation.

**OR**

- C. Provide documentation of positive titer (anti-HBs or HepB Sab) **OR**  
 D. Signed declination for participants who decline vaccination or have not yet completed series **OR**  
 E. Known non responder to vaccination must have signed documentation from healthcare provider showing immunity status.

### MMR (Measles, Mumps, Rubella)

- A. Documentation of 2 vaccinations completed at appropriate time intervals **OR**  
 B. Provide proof of positive titer.

### License

Professional healthcare license may be used in place of National Criminal Background Check. Must be verified annually.

### Varicella (Chicken Pox)

- A. Documentation of 2 vaccinations completed at appropriate time intervals **OR**  
 B. Provide proof of positive titer. **OR**  
 C. Documentation of diagnosis of disease by healthcare provider.

### Additional Requirements (if applicable)

- A. Current AHA BLS for Healthcare Provider Certificate  
 B. Blood Borne Pathogen Education

### Tetanus/Diphtheria/Pertussis

- A. TDaP required once  
 B. TD required every 10 years after TDaP

### Required Education

For questions about these requirements, please contact:  
 Providers and provider students:  
 Brenda Porco-Smith 509-942-2949  
 All other students and licensed professionals:  
 Rachel Wabeke 509-942-2356

# Kadlec Passport Requirements

Name \_\_\_\_\_  
 DOB \_\_\_\_\_  
 School \_\_\_\_\_  
 Program \_\_\_\_\_  
 Current/Previous Employee      Current Extern      Previous Student

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Form verified by (print name) \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date \_\_\_\_\_

## INITIAL REQUIREMENTS

Required immunizations must include mm/dd/yyyy if available.

## ANNUAL REQUIREMENTS

**Tuberculin Status**  
 A. Negative PPD (skin test)  
 TST#1 Place Date \_\_\_\_\_ Read Date \_\_\_\_\_  
 Result: mm \_\_\_\_\_ Neg \_\_\_\_\_ Pos \_\_\_\_\_  
 TST#2 Place Date \_\_\_\_\_ Read Date \_\_\_\_\_  
 Result: mm \_\_\_\_\_ Neg \_\_\_\_\_ Pos \_\_\_\_\_  
 B. Negative IGRA (blood test)  
 Date \_\_\_\_\_ Result \_\_\_\_\_  
  
 \*\*If New Positive: Exam and Negative chest X-ray  
 Date \_\_\_\_\_ **OR**  
 \*\*If Chronic Positive PPD or IGRA: Test 1 Date \_\_\_\_\_  
 Chest X-Ray Date \_\_\_\_\_ Test 2 Date \_\_\_\_\_

**Tuberculin Status** See instructions  
 A. Repeat initial requirements **OR**  
 B. Tuberculosis Screening Questionnaire **OR**  
 C. Not Applicable

**Hepatitis B** (Initial series: 3 shots at 0,1,6 mos. plus titer confirmation 6-8 weeks later.)  
 A. Vaccination Dates  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_ Immunity confirmed by titer  
 3. \_\_\_\_\_ Date \_\_\_\_\_  
 B. If negative titer after initial series, then vaccine #4 and re-titer **OR** vaccines #4-6 and re-titer.  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_ Immunity confirmed by titer  
 6. \_\_\_\_\_ Date \_\_\_\_\_  
 C. Immunity confirmed by titer (anti-HBs or HepB Sab)  
 Date \_\_\_\_\_  
 D. Signed Declination Date \_\_\_\_\_  
 E. Known non responder to vaccination  
 Doctor signature \_\_\_\_\_  
 Date \_\_\_\_\_

**Influenza** Only effective for current academic year  
 A. Proof of seasonal vaccination  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 B. Signed declination  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_

**MMR (Measles, Mumps, Rubella)**  
 A. Vaccination Dates  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_ **OR**  
 B. Immunity confirmed by titer  
 Date \_\_\_\_\_

**Background Check**  
 A. National Criminal Background Check including Excluded Provider Search on OIG and GSA completed initially  
 Date \_\_\_\_\_  
 B. Washington State Patrol Check (WATCH) completed initially then annually  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 C. Criminal Disclosure Statement completed initially then annually  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_

**Varicella (Chicken Pox)**  
 A. Vaccination Dates  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_ **OR**  
 B. Immunity confirmed by titer  
 Date \_\_\_\_\_  
 C. Provided documentation from healthcare provider

**Healthcare License**  
 May be used in place of National Criminal Background Check.  
 A. State \_\_\_\_\_ # \_\_\_\_\_  
 Expiration Date \_\_\_\_\_ **OR**  
 B. Not Applicable

**Tetanus/Diphtheria/Pertussis**  
 A. Tdap Date \_\_\_\_\_  
 B. TD Date \_\_\_\_\_

**Additional Requirements** (if applicable)  
 A. Current AHA BLS for Healthcare Provider Certificate  
 Expiration Date \_\_\_\_\_  
 B. Blood Borne Pathogen Education  
 Date \_\_\_\_\_

**Required Education**  
 Participants may be asked to complete additional education requirements prior to participating in patient care.