INSTRUCTIONS FOR COMPLETING THE PRE-CLINICAL CLEARANCE FORM

Complete the **Pre-Clinical Clearance Form (Appendix A)** with the students' and faculty information to meet the requirement of Hospital Affiliation Agreements and the regulatory compliance requirements. Please submit the completed form one to two weeks prior to the first day of clinical. On-site faculty must comply with all the requirements of the Pre-Clinical Clearance form.

All columns must be completed prior to submitting this form to the clinical facility. Educational institutions must maintain copies of the supporting documents (CPR, liability insurance, CWO, background check, drug screening, Tuberculosis [TB] screening and/or clearance, and immunization/titer records).

Educational institutions are required to keep the supporting documentation on file for seven years. Remember, all documentation is open for affiliate audits.

It is important for schools to read the attestation statement at the bottom of the Pre-Clinical Clearance Form. Falsification of information could lead to termination of affiliation agreements.

Faculty and Student(s) – Enter the on-site faculty name(s) and student name(s).

American Heart Association (AHA) CPR/BLS Expiration Date - Enter expiration date of the CPR/BLS (only Healthcare Provider training accepted) card from AHA. Military Training Network (AHA recognized) cards will be accepted. Hybrid courses are accepted with live skills demonstration.

Liability Insurance Date - Enter coverage dates (i.e. 8/1/15-12/31/15) from the insurance coverage form for each semester.

Community Wide Orientation (CWO) is renewed annually.

Enter the completed date on the (CWO) Certificate. To access CWO on-line presentations, go to http://www.epcc.edu/cwo/Pages/default.aspx or www.epcc.edu and click on the On-line Resources → Community Wide Orientation → Complete all modules and the exam → Print certificate. Educational institutions must maintain the CWO certificate on file. This certificate has a built-in feature to ensure authenticity.

Background Check - Enter the date of the background was cleared by the educational institution.

The background check must include verification of the following:

1. Social Security Number Verification
2. Criminal Search in current and previous counties of residence (minimum 7 years)
3. Violent Sexual Offender and Predator Registry Search
4. OIG List of Excluded Individual/Entities
5. GSA List of Parties Excluded from Federal Programs
6. US Treasury, Office of Foreign Assets Control (OFAC) List of Specially Designated Nationals (SDN)
7. State Exclusion List
8. Faculty/Instructor's (and other applicable persons) License/Certification Verification.

For flagged background, refer to the clinical affiliates' guidelines. If you have questions, contact the Program Dean or Director, who will contact the affiliate.

Note: If the schools contracted a vendor, please verify the vendor has included all of the above.

Negative Drug Screening Date – Enter date of the negative test results. The Drug Screening requirement is 10 panels, to include:

Amphetamines
Barbiturates
Benzodiazepines
Cocaine Metabolites
Marijuana Metabolites
Methadone
Methaqualone
Opiates
Phencyclidine
Propoxyphene

Tuberculosis (TB) Screening required annually. Appendix B

1. Individuals who previously tested negative, have never tested, or aren't sure if previously tested.
    a. Initial 2 Step TB Skin Test (TST)-Effective January 1, 2018, for all students/faculty new to the health programs. .
        i. Initial TB skin test (TST) administered and read 48-72 hours later. Administration date and result documented in "TB #1."

ii. If initial TST negative, 2nd TST must be administered no sooner than 7 days and no later than 21 days after administration of the initial TST. Administration date and result to be documented in TB-#2."

iii. If initial TST positive, **DO NOT ADMINISTER 2ND TST**. Individual needs Chest X-ray (CXR) and annual TB Assessment/Clearance (or equivalent document) from Health Care Provider. Enter the date of the Chest X-ray and the results in appropriate column. Complete the TB Assessment/Clearance Form, **Appendix C**, (or an equivalent document from the HCP) to participate in healthcare agency clinicals. Please note a CXR report must be attached and this document must be signed by the HCP.

2. TB Skin Test Positive (previously) → Requires completed annual TB Assessment/Clearance form, **Appendix C**, (or an equivalent document from the HCP) to participate in healthcare agency clinicals. Please note a CXR report must be attached and this document must be signed by the HCP.

Note: It is highly recommended to complete any and all TB skin testing prior to receiving the MMR and/or Varicella vaccines. MMR or Varicella vaccines could cause a false negative TB skin test result.

Immunizations/Titers – **Appendix E** Please refer to 10/22/13 Algorithm for "Immunization and Blood Titer Requirements for Health Students/Faculty" separate document,

Tetanus/Diphtheria/Pertussis Date (Tdap vaccine)
Effective Jan 1, 2018, the individual must have a documented Tdap at age 11 or older and then Td and/or Tdap should be administered every 10 years. Enter the date of the most recent Tdap/Td.

Varicella (Chicken Pox)Titer = Varicella IgG **Appendix C**
Enter "date" and result "(+) or (-)" in first column. If results are positive, no additional vaccines or titers are required. If results are negative, enter the date of the first dose of the next Varicella series under the negative sign and the date of the second dose in the second column. The two doses of varicella vaccine must be given ≥ 28 days apart. After 2nd Varicella vaccine series, no additional vaccines or retiters are required. Refer to **Appendix C** for further information.

Note: It is highly recommended to complete any and all TB skin testing prior to receiving the MMR and/or Varicella vaccines. MMR or Varicella vaccines could cause a false negative TB skin test result.

M.M.R. (Measles, Mumps, Rubella) = IgG for Measles, Mumps, & Rubella
Appendix D

Enter "date" and result "(+) or (-)" in first column. If results are positive, no additional vaccines or titers are required. If results are negative enter the date of the first dose of the next MMR series under the negative sign and the date of the second dose in the second column. The two doses of MMR must be given ≥ 28 days apart. After 2nd MMR vaccine series, no additional vaccines or retiters are required. Refer to **Appendix D** for further information.

Note:

1. **Varicella and MMR are live vaccines and must be given the same clinical day or ≥ 28 days apart. Also, the TB skin test must be administered the same clinical day as the MMR and/or Varicella, otherwise, the individual must wait ≥ 28 days (after a Varicella or MMR) to receive a TB skin test (MMR or Varicella could cause a false negative TB result). It is highly recommended to administer the TB skin test first, have it read in 48-72 hours, and then get the MMR and/or Varicella.**

2. **For those individuals for which MMR and/or Varicella are medically contraindicated, a healthcare provider signed medical clearance form is required. As per institutional policy, masking may be required for these individuals.**

3. **It is highly recommended to complete any and all TB skin testing prior to receiving the MMR and/or Varicella vaccines. MMR or Varicella vaccines could cause a false negative TB skin test result.**

H.B.V. (Hepatitis B) = Hepatitis B Surface Antibody Appendix E

Enter "date" and result "(+) or (-)" in first column. If results are positive, no additional vaccines or titers are required. If results are negative, enter the date of the first dose of the next series under the negative sign and the date of the second and third doses in the second and third columns. A Hepatitis B retiter is required 4-6 weeks after the third dose of the second documented series. Refer to Appendix E for further information. Non-responders to the vaccination and who are HBsAg negative should be considered susceptible to HBV infection and must be counseled using the Hepatitis B Non-Responder Counseling" form **(See Appendix F).** This form must be kept on file at the academic institution.

If an individual meets the above outlined "non-responder status" criteria, "NR with the date" must be documented in the Hepatitis B titer column on the Preclinical Clearance Form,
(See Appendix A).

Flu Vaccine Date (seasonal) - Enter date of the flu vaccine. If the individual declines the flu vaccine, enter "D" and the date declined in the column. This vaccination is required from October 1through March 31 annually (or as specified by the clinical facility's policy).

Note: As per institutional policy, masking may be required in the absence of a documented seasonal Flu vaccine.

The Program Director or coordinator verifies that the enclosed information is accurate and on file at his/her Institution. The clinical facility may audit these records at any time at the educational institution.

Facility Specific – Enter information requested by individual clinical facilities if applicable.

References

CDC.gov.
www.dshs.state.tx.us/idcu/disease/tb

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El Paso Nurse Educators Council

EPNEC

Pre Clinical Clearance Form

Revised Effective 02/2018

Program: _____ Initial Semester: ____ Clinical Affiliate: _____

Course Director/Instructor: _____ Rotation Dates: _____

Faculty/Student Name	AHA CPR Expiration Date	Liability Insurance (Coverage dates)	Community Wide Student Orientation (Date Completed)	Background Check (Cleared date)	Negative Drug Screening** Date	TB #1 Skin Test Results Date	TB #2 Skin Test Results Date	TB Annual or Chest/Xray CXR Date & Assessment	Tdap/Td	Varicella Date (+/-) Titer		M.M.R. Dates (+/-) Titer		H.B.V. (Hep B) #1 #2 #3 Dates (+/-) Titer			Flu Vaccine or Declination Date

**** Control Substance Testing (Drug screening) – 10 panel screening is required. (+ = positive - = negative)**

The Course Director or designee hereby verifies that the enclosed information is accurate and on file at his/her Institution. Furthermore, the Course Director/designee verifies that the background check for the faculty and students meets the requirements of Level One which consists of the following elements: 1) Social Security Number Verification; 2) Criminal Search (minimum 7 years) in current and previous counties of residence; 3) Violent Sexual Offender and Predator Registry Search; 4) OIG List of Excluded Individuals/Entities; 5) GSA List of Parties Excluded from Federal Programs; 6) US Treasury, Office of Foreign Assets Control (OFAC), List of Specially Designated Nationals (SDN); and 7) State Exclusion List (http://www.hhsc.state.tx.us/OIE/exclusionlist/exclusion.asp). For Instructors Level Two which consists of: 1) All of Level One elements; 2) License Verification; 3) Certification Verification; and 4) Employment Verification is only to be conducted for licensed/certified personnel (include reason for separation and eligibility for re-hire for each employer). Based upon information made available and to the best of my knowledge there are no prior or pending investigations, reviews, sanctions or peer review proceedings; or limitations of any licensure, certification or registration. I understand that an annual compliance audit will be conducted by the Facility/Hospital on the premises of the Institution of five percent (5%) or a minimum of thirty (30), such background investigation files as authorized by the participants under the Fair Credit Reporting Act (FCRA). The background check reports in the possession of the Institution constitutes an "educational record" under the Family Educational Rights and Privacy Act (FERPA), codified 20 U.S.C. 1232g. In accordance with FERPA, the information must be handled by individuals at the Facility who have a legitimate need to verify participant qualifications.

Print Name of Course Director/Designee/Title _____ Signature of Course Director/Designee/Title _____ Phone Number _____ E-mail Address _____ Date _____

Note: History of a disease (measles, chicken pox or mumps) is no longer an exemption from vaccination or titer requirements.

Revised 10/2015, 11/17,2/18

Initial 2 Step and Annual Follow-Up TB

TB Skin Test Guide

For Individuals who have not previously tested positive, have never tested, or aren't sure

TB Skin Test- Read in 48 - 72 hours
Only for individuals who have not previously tested positive

Negative Results
Must include validation signature/stamp

2nd TST must be administered no sooner than 7 days and no later than 21 days after

Cleared for TB, Ok to participate in health care agency clinicals

TB Skin Test Assessment Guide

For individuals with a previously positive TB skin test

TB Skin Test Assessment
For individuals with a previously positive TB skin test

See Health Care Professional (HCP), Physician, NP, PA licensed in the U.S.

HCP determines if patient needs additional testing (including a new CXR)

HCP writes a TB clearance presciption/letter or completes TB Assessment Clearance Form

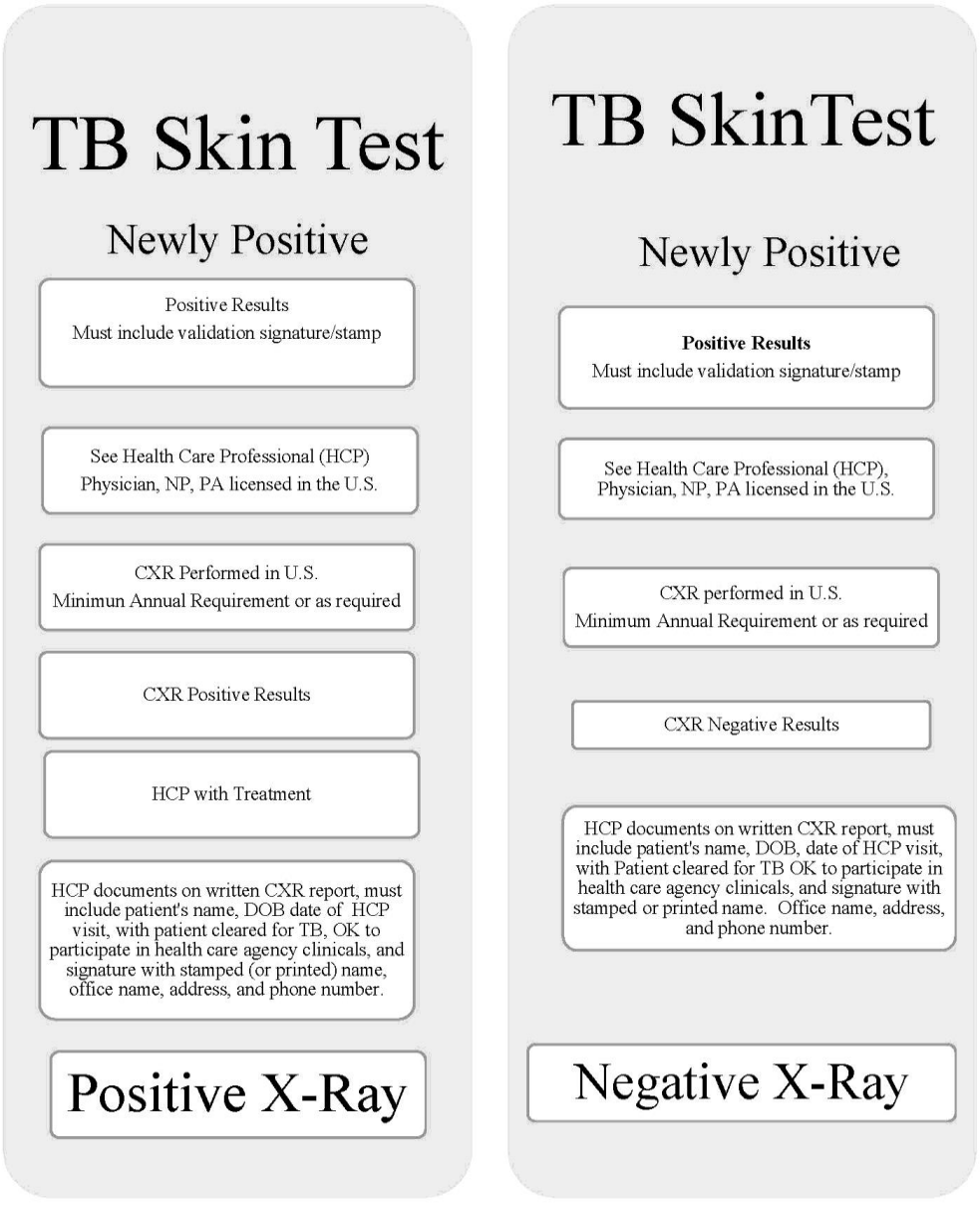
TB clearance prescription/letter or TB Assessment Form must include patient's name, DOB, Date of HCP visit, with patient cleared for TB, OK to participate in health care agency clinicals, and signature with stamped or printed name, office name, address, and phone number.

A copy of most recent CXR written report performed in the U.S., signed by the HCP, must be submitted with the TB clearance prescription letter/TB Assessment Form

Reviewed 2/18

TB Test Newly Positive Guide

For individuals with a newly Positive TB Test



Drug Allergies	**N ☐**	**Y ☐**
Food Allergies	**N ☐**	**Y ☐**
Environmental Allergies	**N ☐**	**Y ☐**
Pregnant	**N ☐**	**Y ☐**

TUBERCULOSIS (TB) ASSESSMENT/CLEARANCE
NEW and PREVIOUSLY TB SKIN TEST POSITIVE INDIVIDUALS

Name_____ Birth Date_____ Today's Date_____

Birth Country_____ Current Country of Residence_____ Years in Current Country_____

Previous TB skin test (TST) WITH documentation: ☐No/Unknown OR ☐Yes Date_____ Result: ☐Neg ☐Pos

Previous Positive TST WITHOUT documentation: ☐No/Unknown OR ☐Yes Date_____ Result: ☐Neg ☐Pos

Quantaferon Gold Test Date_____ Result_____

History of treatment of TB infection or disease: ☐No/Unknown OR ☐Yes Treatment Dates:_____

TB Signs/Symptoms Review:
Do you have any of these symptoms?

Fever ☐N Y☐ Chills ☐N Y☐ Night Sweats ☐N Y☐
Cough☐N Y☐ Productive Cough☐N Y☐ Coughing up blood N Y ☐ ☐
Weight Loss (≥10%) ☐N Y☐
Enlarged cervical lymph nodes ☐N Y☐

Other: _____

History of prior exposure to someone with TB disease: ☐No/Unknown OR ☐Yes Date_____
Exposure during medical procedure: ☐No/Unknown OR ☐Yes Date_____
Exposure in congregate (group) setting: ☐No/Unknown OR ☐Yes Date_____
Exposure in household of person with TB disease: ☐No/Unknown OR ☐Yes Date_____

History that may increase chance of prior exposure to someone with TB disease:

☐N Y☐ Residence or travel in country where TB is common (Mexico, Latin America, Caribbean, Africa, Eastern Europe, or Asia) Place/Dates:_____
☐N Y☐ Resident or employee of correctional facility Place/Dates:_____
☐N Y☐ Resident or employee of homeless shelter Place/Dates:_____
☐N Y☐ Resident or volunteer in disaster shelter Place/Dates:_____
☐N Y☐ Resident of long term care facility Place/Dates:_____
☐N Y☐ Health care worker Place/Dates:_____
☐N Y☐ Injection drug use Place/Dates:_____

REFERRAL
Chest x-ray/Date:_____ Results:_____ **CXR Report Must be Attached to this form**

Patient Cleared for TB, May Participate in Health Care Agency Clinicals: ☐NO ☐YES

Comments:_____

Health-Care Provider Signature/Title: _____ **DATE:** _____

Health-Care Provider Printed Name/Title:_____

Office Address:_____ **Office Phone #:**_____

Developed by EPCC RG Boarder Health Clinic. (915) 831-4016

Revised September 2014 P.Shanaberger RN, FNP-C/M.Kaough RN, MSN, CCRN

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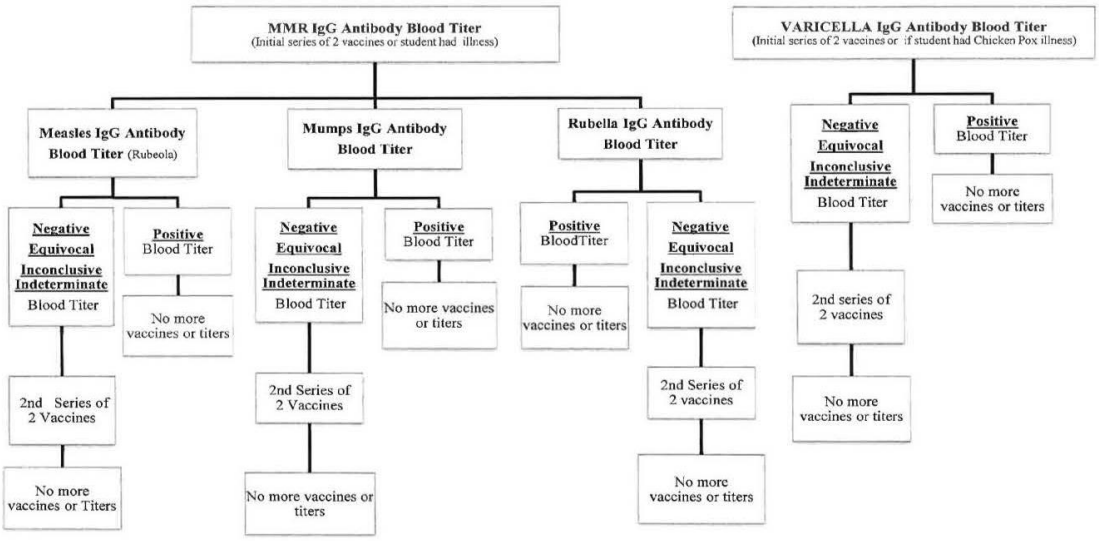
MMR & Varicella Immunization & Blood Titer Requirements for Health Students/Faculty



Student counseling is done for negative titers to explain a "non-responder" status and related pertinent information and precautions.

P. Shanaberger RN, FNP-C/Patricia C. Montes, EPCC-Lab Facilities Supervisor (915)831-4495 April 22, 2015

Note: TB skin test must be administered the same clinical day as the MMR and/or Varicella, otherwise, one must wait > 28 days (after a Varicella or MMR) to receive TB skin test (MMR or Varicella could cause a false negative TB result).

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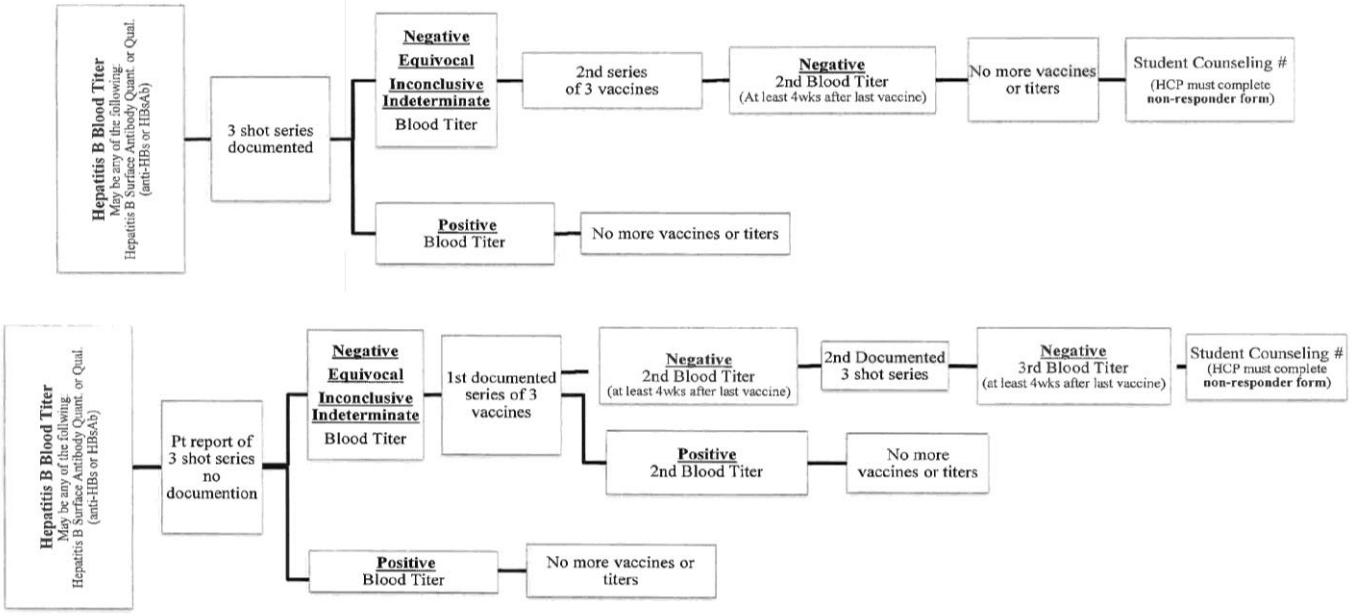
HBV Immunization & Blood Titer Requirements for Health Students/ Faculty

Immunization and Blood Titer Requirements for Health students based on combining the UMC & HCA protocols and meeting the most stringent components. Blood titer results for Hepatitis B, Measles, Mumps, Rubella, and Varicella are required and students are **recommended to wait 4-6 weeks after finishing the last dose of a series before having blood Titers**.



Student counseling is done for negative titers to explain a "non-responder" status and related pertinent information and precautions.

P. Shanaberger RN, FNP-C/Patricia C. Montes, EPCC-Lab Facilities Supervisor (915)831-4495 **April 22, 2015**

Hepatitis B Non-Responder Counseling

Date: _____

Patient Name: _____

Date of Birth: _____

A vaccine non-responder is someone who does not build up an adequate immune response after receiving two, 3 shot series of the HBV vaccine. Approximately 5-15% of people who receive the vaccine are considered non-responders. This is especially important for health-care workers who may be at increased risk of exposure to HBV. Documentation of two complete Hepatitis B series, a follow-up negative HBsAb titer, and a HBsAg negative titer, are required to declare non-responder status. Once declared as a non-responder, this individual will not be required to receive any more Hepatitis B vaccine or HBsAb titers.

Non-responders to vaccination and who are HBsAg negative should be considered susceptible to HBV infection and should be counseled by a physician, nurse practitioner, or physician assistant, currently licensed in the United States, regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable percutaneous or permucosal exposure to HBsAg positive blood.

HBV Vaccine Date	HBsAb titer Date	HBsAb Result	HBsAg titer Date	HBsAg Result	Comments

The patient and provider signatures below attest this HBV non-responder patient has received the necessary HBV prophylaxis and post-exposure counseling.

_____ _____

Patient Signature Date