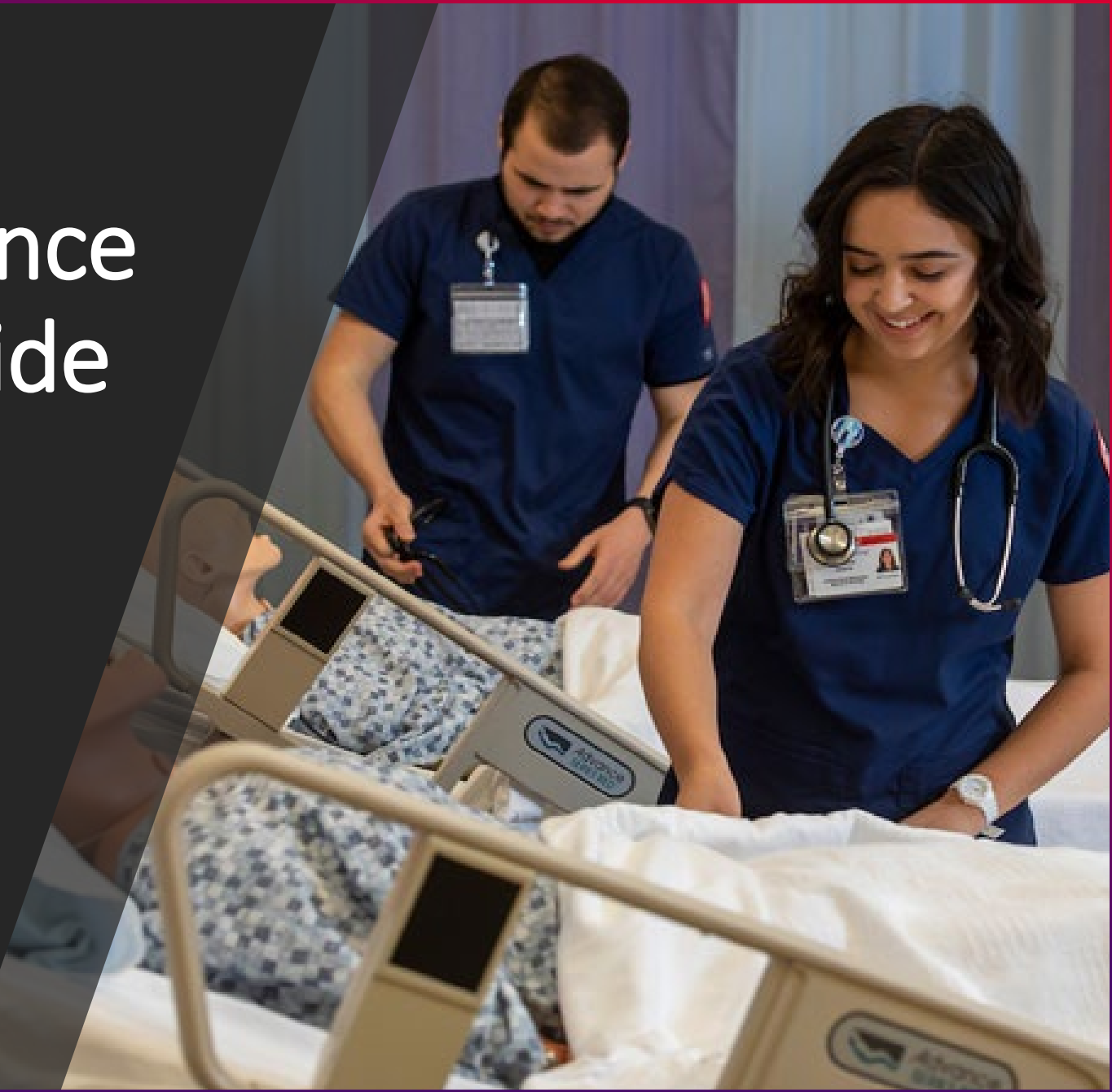


# Compliance Item Guide

Linfield University  
School of Nursing



# Complio by American DataBank

- Background Checks
- Drug screens
- Immunization-records & certifications

*For information on setting up your Complio account, go to:*

[www.linfield.edu/compliance](http://www.linfield.edu/compliance)



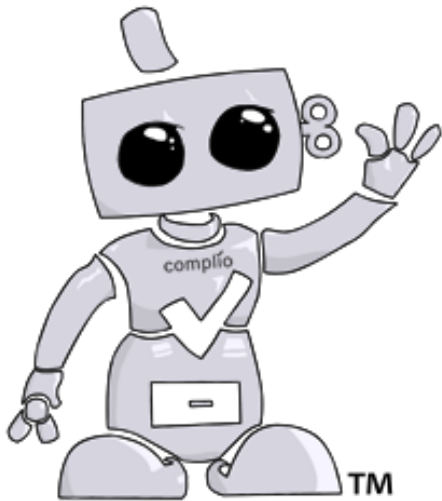
# WHY IS COMPLIANCE IMPORTANT?

- Compliance is a set standard by the Oregon State Board of Nursing (OSBN) for all students who are in a recognized nursing program which meet the educational requirements in order to sit for the National Council Licensure Examination (NCLEX-RN or often referred to as NCLEX). Candidates who successfully pass the NCLEX are determined as fit to begin entry level nursing practice work.
- Additionally, compliance standards will be required in various facets as a working practicing registered nurse (RN). Meeting and maintaining program compliance requirements will prepare you for your future professional career.

# IMMUNIZATION REQUIREMENTS

- Required by everyone, no exceptions
- Clinical sites can deny students based on incomplete or expired vaccines or screenings
- Must be compliant ***at all times*** while in the nursing program

# COMPLIO TIPS



## KEY:



**Compliant**



**Pending Review**



**Non-compliant**



- Watch for emails from [non-reply@americandatabank.com](mailto:non-reply@americandatabank.com)
- Give Complio 3-5 business days to review submitted items
- DO NOT delay action to achieve or remain in compliance

# REACH COMPLIANCE BY YOUR GIVEN ADMISSIONS DEADLINE!

## CONSEQUENCES:

- Failure to reach compliance by the given admissions deadline will result in the cancellation of your admission.
- Failure to maintain compliant status as a current student will impact your ability to attend clinical.
  - Missed clinical experiences due to non-compliance are counted as an absence. Absences can lead to failure of a clinical course.



If your Complio account looks like this by your given deadline, you are ready to begin classes!

complio  Home

 American DataBank

Username:

 **Immunization/Compliance**  
Linfield University TBSN

 Background Screening

Institute:

Linfield  
University

Overall Compliance Status **Compliant**  (14/14 Compliant)



# REQUIRED COMPLIANCE CATEGORIES

1. MMR (Measles, Mumps, and Rubella)
2. Varicella (Chickenpox)
3. Hepatitis B (HBsAB)
4. Tuberculosis (TB)
5. TDaP (Tetanus, Diphtheria, Pertussis)
6. Influenza
7. BLS Certification
8. Health Assessment Form
9. Essential Functions Form
10. Health Insurance
11. COVID-19
12. Confidentiality and Release for Simulation
13. Background Check
14. Drug Screening



# Uploading Documents to Complio



***Allow Complio 3-5 business days to review and approve submitted items.***

***Plan accordingly to meet necessary deadlines!***



Acceptable document examples: Lab reports, clinical records, employee records, school records, state alert system reports, immunization cards or provider letters



# NAME YOUR DOCUMENTS AND ADD DESCRIPTIONS!



*Organizing your documents will make the process to compliance easier!*

File Name	File Type	Size (KB)	Description
Linfield 20190308 EssentialFunctions_SignRR	pdf File	40.00	
HealthAssessmentForm Linfield college 2	pdf File	215.00	Health Assessment Form 2
HealthAssessmentForm Linfield college 3	pdf File	253.00	Health Assesment Form3
HealthAssessmentForm Linfield college 1	pdf File	325.00	Health Assesment Form1
Essential-Functions-Form Linfield college	pdf File	471.00	Essestial - Functions Form
Insurance card	pdf File	155.00	INSURANCE CARD
drug test result	pdf File	344.00	DRUG TEST RESULT
backrgroun check	pdf File	433.00	backgroun check
CPRcard	pdf File	89.00	CPR CARD 2019
Results_9017111315222200 (8)	pdf File	47.00	RESULTS HEALTH
Hepatitis B result1	pdf File	120.00	HEPATITIS B RESULT1
hepatitis B result2	pdf File	173.00	HEPATITIS B RESULT2
Immunizations 06	pdf File	194.00	IMUNIZATIONS 2018
Influenza and imminizations	pdf File	150.00	IMUNIZATIONS AND INFLUENZA
Urine drug check	pdf File	284.00	URIN DRUG CHECK
Varicella- zoster1	pdf File	511.00	VARICELLA ZOSTER 1



**Organized Example**



**Unorganized Example**



File Name	File Type	Size (KB)	Description
F405F825-4642-4198-AAAD-84F5C1C4B95D	pdf File	194.00	
IMG_8296	pdf File	92.00	
IMG_8295	pdf File	112.00	
IMG_8294	pdf File	89.00	
CD2F6910-025D-4718-9E12-DCA82BA8B118	pdf File	122.00	
0440C8E4-2442-4834-9921-1DF514C418CF	pdf File	126.00	
8C543EDB-7C25-41E1-BA65-DD8A14FB0E8B	pdf File	141.00	
F354FB04-888C-4A7C-80FE-6C32B1974B64	pdf File	109.00	
56010A7B-CA57-4192-A005-AA92F4E3F82C	pdf File	110.00	
430A7C87-68EC-4368-A771-905933AB7126	pdf File	76.00	Hep B



# ENTER EACH DOSE DATE FOR MULTI-DOSE CATEGORIES!



- Multi-Dose Categories include:
  - MMR, Varicella, Hepatitis B, and COVID-19


MMR + Enter Requirements Incomplete

Add New Requirement

**MMR:** You must submit A or B:  
A) 2 doses of the MMR vaccine  
B) Positive Titers for Measles, Mumps, and Rubella  
Please note - if you submit a non-immune titer for Measles, Mumps, or Rubella, you must submit one (1) Post-Titer MMR Boosters dated AFTER your non-immune titer.

Select a requirement:

- SELECT--
- MMR Dose 1
- MMR Dose 2
- Measles Titer
- Mumps Titer
- Rubella Titer
- Post-Titer MMR Booster 1

 To enter each dose, you must go back to this drop-down menu and select the specific requirement



# ENTER THE CORRECT DATE!



This date is for when you received the vaccine, not the current date you are uploading your documentation.

+ [Enter Requirements](#)

Incomplete

MMR

## Add New Requirement



**MMR:** You must submit A or B:

A) 2 doses of the MMR vaccine

B) Positive Titers for Measles, Mumps, and Rubella

Please note - if you submit a non-immune titer for Measles, Mumps, or Rubella, you must submit one (1) Post-Titer MMR Boosters dated AFTER your non-immune titer.

Select a requirement:

MMR Dose 1

Document:

-- SELECT --

Date:

Select a date

Expiration Date:

Upload Additional Documents:

Drop files to attach, or [Browse](#)

Note:

Submit Cancel

# CATEGORY BREAKDOWN

# COMPLIANCE CATEGORIES

1. MMR (Measles, Mumps, and Rubella)
2. Varicella (Chickenpox)
- 3. Hepatitis B (HBsAB)**
- 4. Tuberculosis (TB)**
5. TDaP (Tetanus, Diphtheria, Pertussis)
6. Influenza
- 7. BLS Certification**
- 8. Health Assessment Form**
9. Essential Functions Form
10. Health Insurance
11. COVID-19
12. Confidentiality and Release for Simulation
13. Background Check
- 14. Drug Screening**

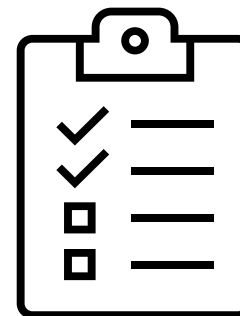
We recommend paying attention to these specific categories first, as they may require further scheduling



# SCHEDULE YOUR DOCTOR'S APPOINTMENTS ASAP!

## First Doctor's Appointment Checklist:

- Obtain Immunization Record
- Complete Health Assessment Form
- Check when you received your TDaP Vaccine
  - If it's been 10 years, you will need to receive the TDaP Booster
- Schedule Hepatitis B Surface Antibody (HbsAB) Titer
- Schedule Tuberculosis PPD Skin Test or QuantiFERON GOLD TB Test/ T-spot



# MMR

- Submit proof of A or B:
  - A) 2 doses of the MMR vaccine
  - B) Positive titers for Measles, Mumps, and Rubella
- Note, if any titer is negative, submit one post-titer MMR Booster dated after the non-immune titer



## What is a Titer?

A blood test used to determine the presence (qualitative) and amount (quantitative) of antibodies in the blood.

Positive Titer = Immune  
Negative Titer = Not immune

# VARICELLA

- Submit proof of A or B:
  - A) 2 doses of the Varicella vaccine
  - B) Positive Varicella titer
- Note, if your titer is negative, submit two varicella vaccine doses dated from anytime



# HEPATITIS B (HbsAB)

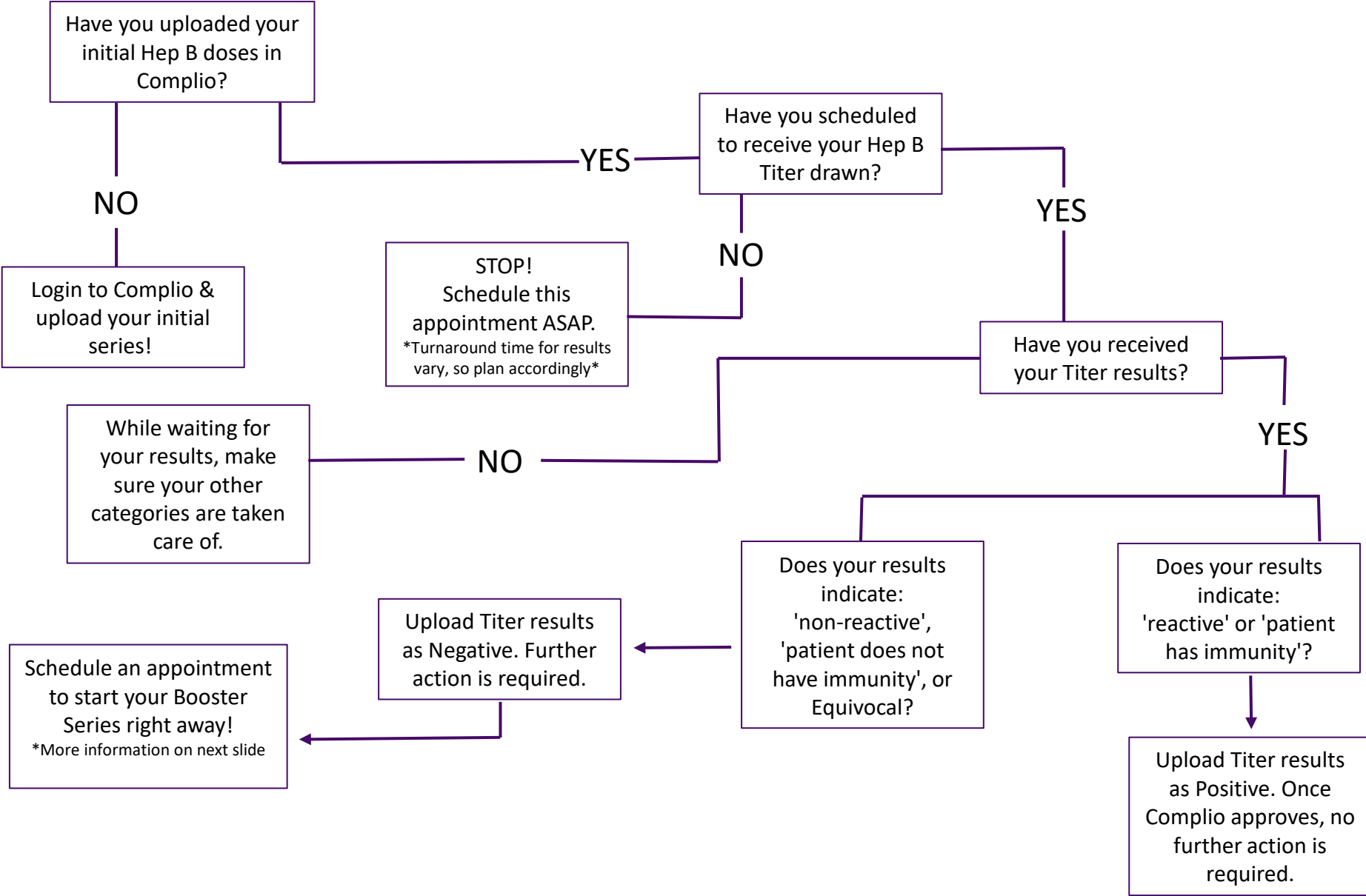
- Submit proof of A and B (**Must provide both!**):
  - A) Proof of your initial Hepatitis B Doses
    - Hepatitis B Dose 1
    - Hepatitis B Dose 2
    - Hepatitis B Dose 3
  - B) Positive Hepatitis B (HbsAB) Titer



*There are different Hep B Titers/tests. Be sure the test you order is a Hepatitis B Surface Antibody (anti-HBs or HBsAB)*

# HEPATITIS B FLOWCHART

**START HERE !**





## NEGATIVE HEPATITIS B TITER, WHAT ARE MY NEXT STEPS?



- You are required to begin the Post-Titer Hepatitis B Booster Series + Repeat Hepatitis B Titer to prove immunity.
  - You must receive at least (1) Post-Titer Hepatitis B boosters, but may do up to (3) as recommended by provider.
    - Post-Titer Hepatitis B Booster 1
    - Post-Titer Hepatitis B Booster 2
    - Post-Titer Hepatitis B Booster 3
    - Repeat Titer – dated at least 30 days after Booster 1, 2, or 3
- Temporary compliance is granted as you work through the initial or booster series. Timeframe for temporary compliance noted below:
  - Hepatitis B Dose 1 or Booster 1 = 45 days
  - Hepatitis B Dose 2 or Booster 2 = 6 months
  - Hepatitis B Dose 3 or Booster 3 = 2 months

# TUBERCULOSIS (TB)

- Submit proof of A or B:
  - A) Negative 2-Step PPD (Skin Test)
  - B) Negative Initial QuantiFERON TB Test/T-spot
- If your chosen test is positive:
  - Upload a Negative Chest X-Ray
  - Submit the TB Screening Form found in Complio
    - Renewal timeline: Annually



# DIFFERENCE BETWEEN TB SKIN TEST AND T-SPOT

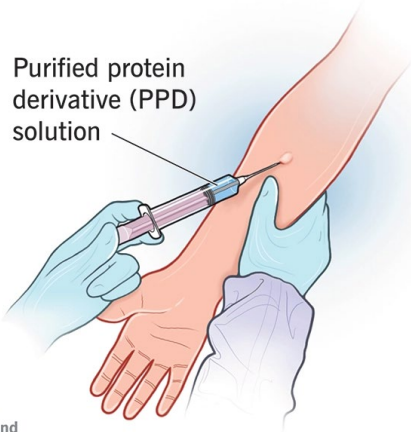


## TB SKIN TEST (PPD)

Intradermal Injection

**TB (tuberculosis) skin test**  
*Intradermal injection*

Purified protein  
derivative (PPD)  
solution



  
Cleveland  
Clinic  
©2021

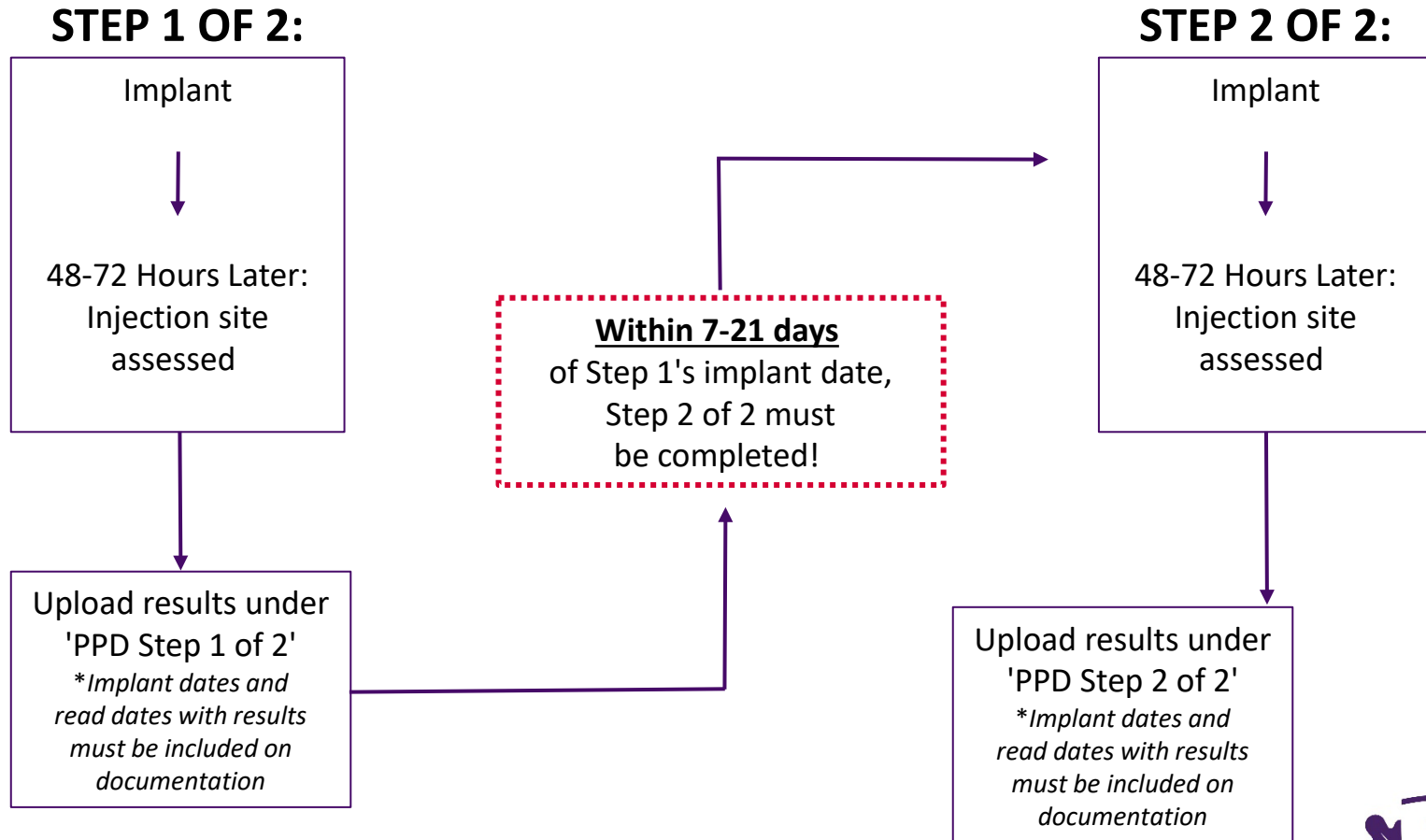


## T-SPOT TEST

Blood Collection



# 2-STEP PPD PROCESS = 2 NEGATIVE PPD RESULTS



*No exceptions can be made if  
timeframe between two steps are not  
completed within 7-21 days!*

# TETANUS, DIPHTHERIA, PERTUSSIS (TDaP)

- Submit proof of TDaP dated on or after your 11th birthday
  - If 10 years have passed, you are required to submit a TD Booster



*TDaP and DTaP are **not** the same!  
TDaP is the **ONLY** acceptable vaccine for  
this category, no exceptions.*

# INFLUENZA

- This category **does not** impact your compliance status between April 1st to October 31st
  - From October 31st to March 31st, documentation of the influenza vaccine is required. You must get a flu shot every year.
  - If you opened Complio before April 1st, this category shows as incomplete
- Submit proof of A or B, no earlier than August 1st to apply to the upcoming Flu Season
  - A) Flu Vaccination
  - B) Flu Declination Form (Medical Exemptions only, and must be accompanied by a provider's signature)



# BLS CERTIFICATION

- BLS (Basic Life Support) must be American Heart Association
  - No exceptions
  - Renewal timeline: bi-yearly
- Cascade Training Center:
  - Registration Link for CPR/BLS for Healthcare  
Provides Course: <https://classes.healthcare.com/linfield/>
    - At checkout hit 'Click here if you DON'T have a Voucher!', **student discount should already be applied**

The screenshot shows a web browser at the URL [classes.healthcare.com/linfield/book\\_gateway.cfm](https://classes.healthcare.com/linfield/book_gateway.cfm). The page features the Linfield University and Cascade Training Center logos. A blue banner reads "Please Verify your Personal Info" with a note: "If your information is correct, please enter your Voucher, manager's name and employee ID. If any information is incorrect, please click the 'Edit' link." Below this are two main sections: "Verify Your Information" and "Voucher/Payment". The "Voucher/Payment" section contains a link "Click here if you DON'T have a voucher" circled in red, and a "Validate Voucher" button. A hand-drawn black bracket spans the top of the page, and a black arrow points from the bracket down to the circled link.

Verify Your Information	
Name:	<input type="text"/>
Address:	<input type="text"/>
Phone:	<input type="text"/>
Email:	<input type="text"/>
<input checked="" type="checkbox"/> Edit Personal Info	

Voucher/Payment	
<a href="#">Click here if you DON'T have a voucher</a>	
Voucher:	<input type="text"/>
Manager's Name:	<input type="text"/>
Employee ID:	<input type="text"/>
<input type="button" value="Validate Voucher"/>	

# HEALTH ASSESSMENT FORM



Username:

 **Immunization/Compliance**  
Linfield University BSN

 Background Screening


Institute:


Linfield  
University


Overall Compliance Status **Compliant**  (14/14 Compliant)


Applicant Name:

Change


 Edit Profile

 Get Started  
Know how to become compliant?

 Order History

 Message Center

 Report

 Required Documents

1) Access Health Assessment form  
in Required Documents

- You will complete page 1
- A healthcare provider will complete page 2

2) Upload both pages into Complio



Student/Campus Health Centers or general health care clinics can assist with your immunizations and other requirements such as the Health Assessment.



# DOUBLE CHECK EACH PORTION OF THIS FORM IS COMPLETELY FILLED OUT BEFORE LEAVING YOUR APPOINTMENT!



**LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT STUDENT FORM**  
*To be completed by student*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Former Illnesses  
No  Yes  If Yes, please explain: \_\_\_\_\_

Former Injuries  
No  Yes  If Yes, please explain: \_\_\_\_\_

Former Hospitalizations  
No  Yes  If Yes, please explain: \_\_\_\_\_

Comments if applicable: \_\_\_\_\_

Anemia	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Arthritis	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Asthma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Back Injuries	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Birth Defect	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Bladder Infections	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Bowel Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Hearing Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Heart Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
High B/P	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
High Cholesterol or Lipids	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Infectious Mono	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Kidney Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Liver Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Rheumatic Fever	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Seizures	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Thyroid Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Ulcer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____
Visual Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>	_____

Current medications: \_\_\_\_\_

Allergies including medications and other substances: \_\_\_\_\_

Present or chronic medical conditions: \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

1 March 2020

**LINFIELD SCHOOL OF NURSING: HEALTH ASSESSMENT PROVIDER FORM**  
*To be completed by provider*

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Resp \_\_\_\_\_

Vision (Snellen) \_\_\_\_\_ / \_\_\_\_\_ R/L Corrected \_\_\_\_\_ / \_\_\_\_\_ R/L  
Near Vision \_\_\_\_\_

Hearing \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_

Check if normal: \_\_\_\_\_ Comments if applicable: \_\_\_\_\_

- General Appearance
- Head and Scalp
- Face and Skin
- E.E.N.T.
- Neck
- Heart
- Lungs
- Chest
- Abdomen
- Back and Spine
- Extremities
- Lymphatics
- Neurological
- Genitourinary

**Is the person seen in general health, adequate to allow participation in a nursing education program?**  
Yes  No   
Comments/concerns if applicable: \_\_\_\_\_

Physician or Nurse Practitioner \_\_\_\_\_  
Practice or Facility \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_

**THIS INFORMATION IS CONFIDENTIAL**

2 March 2020

 Most common sections where information is missing.



This is the ONLY acceptable document in this category, no exceptions.

# ELECTRONICALLY SIGNED FORMS VIA COMPLIO

## Essential Functions Form

### LINFIELD COLLEGE SCHOOL OF NURSING ESSENTIAL FUNCTIONS

All students must be able to perform and/or develop the following essential functions in order to succeed at Linfield-Good Samaritan School of Nursing. If at any time your ability to perform these essential functions changes while enrolled in the nursing program, you must notify the clinical course coordinator.

Essential Functions	Description	Examples
Sensory	Auditory, visual and tactile ability	Monitor and assess health status (e.g., assess color changes in the skin: hear heart, lung and breath sounds).
Communication	Verbal, nonverbal, reading, writing	Interact effectively with individuals, families, groups and health care team members from a variety of social, emotional, cultural and intellectual backgrounds; effectively use verbal and nonverbal communications; use responsive and empathetic listening to establish rapport; effectively use appropriate information technology for research and patient care; understand and use correct professional terminology when communicating with other health care professionals; document nursing care clearly; write papers accurately and with clarity.
Motor	Physical ability, coordination, stamina	Perform cardiopulmonary resuscitation (CPR); transfer and lift persons; move from room to room and maneuver in small spaces; provide routine and emergency nursing care.
Cognitive	Critical thinking ability	Measure and calculate drug dosages and solutions; comprehend, memorize, reason, analyze, prioritize and synthesize information; integrate theory with clinical practice; effectively problem solve; use good clinical judgement based on critical, analytical and creative thinking; as well as intuitive processes; recognize personal learning needs from the clinical setting.
Behavioral/Social/Emotional	Emotional stability, capacity for self-reflection and change	Function effectively under stress; adapt to changing environments and uncertainties in clinical situations; be flexible; use effective organizational and time management skills; respect and accept constructive criticism; respond appropriately to evaluation; be assertive; demonstrate professional responsibility and accountability in nursing practice

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (print please) \_\_\_\_\_

Please read this document, sign and submit through the clinical compliance system.

## Confidentiality and Release For Simulation



2900 NE 132nd Avenue  
Portland, OR 97230  
T 971.369.4100

LINFIELD.EDU

Experiential Learning Center  
Confidentiality and Release Form for Simulation

### 1. CONFIDENTIALITY OF INFORMATION

During your participation in courses that use simulation experiences, you will likely be an observer of the performance of other individuals in managing healthcare events. As a participant in these activities in whatever role, you are asked to maintain and hold confidential all information regarding the performance of specific individuals and the details of specific scenarios.

By signing below, you acknowledge to having read and understood the statement and agree to maintain the strictest confidentiality about any observations you may make about the performance of individuals.

### 2. RELEASE FOR STILL PHOTOGRAPHS AND VIDEOTAPES

During simulation experiences, recordings may be made. These recordings can be accessed by students and instructors for debriefing and student reflection. I authorize instructors and administrators of the Experiential Learning Center to publicly show still photographs (slides or prints) and/or videotapes depicting me during this course. I understand that, unless otherwise approved by me, I will not be specifically identified, and that the photographs will be shown only for educational, research, or research administration purposes. No commercial use of the photographs (slides or prints) and/or videotapes will be made without my written permission. At the end of the course or semester when access is no longer required, recordings will be deleted from the ELC audio-visual system.

PRINT NAME \_\_\_\_\_ Linfield EMAIL \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Linfield-Good Samaritan School of Nursing Experiential Learning Center  
Last reviewed January 2021



*It is your responsibility to inform your Integrated Experiential Learning (IEL) Coordinator if any essential functions are impacted as you progress through the semester.*

# BACKGROUND CHECK & DRUG SCREENING ORDER

*Must be completed within 3 months of program start date, per OHA policy. Once you receive the appropriate password & instructions from Admission, you may begin your 'Background Check & Drug Screening Bundle' order.*

## Background Check

Criminal history on a background check:

- May be cause to deny or revoke admission to Linfield's School of Nursing
- May impede student progression and placement in clinical sites
- May be cause for a student to be denied nursing licensure following graduation

## Drug Screening

- Completed at a pre-authorized collection site provided by Complio
  - No exceptions
- From the time you place your order, you have **30 business days** to complete the collection
  - If not, this category will be flagged as incomplete



*Once Background Check and Drug Screening are completed, Complio will upload it your account automatically.*



# DRUG SCREENING DETAILS

- You **MUST** call site(s) directly to schedule an appointment
  - Selecting your pre-authorized collection site at the time of order, **does not** automatically schedule an appointment
  - *Walk-ins are accepted by most sites, but may include a wait-time*
- If the collection site you chose at the time of order no longer works out, your registration is transferable to an alternate location, so long as it is within the same lab network (Quest or LabCorp) as the location you initially selected. Call the new location to make an appointment, and contact Complio to inform them of your location change.
- Flagged Drug Screens
  - 'Positive' or ' Negative Dilute' will not be accepted and you need to repeat the drug screening
    - Recollection fees are an additional expense to your original package



*Avoid drinking excessive amounts of liquids (12+ oz) 3-4 hours before specimen collection*

# HEALTH INSURANCE

- Submit proof of your Health Insurance Coverage
  - Be sure the document displays your name or add a supplement document to the item

# COVID-19

Submit proof of A, B or C:

- A. (1) Bivalent Dose of the Pfizer or Moderna vaccine
- B. (2) Monovalent Doses of the Pfizer or Moderna vaccine
- C. (1) Monovalent Dose of the Johnson & Johnson vaccine



*COVID-19 Exemptions will NOT be accepted!*



# WHEN IN DOUBT, COMMUNICATE!



- We can't help you, unless you let us know there's an issue!
- Check email regularly!

# BEFORE YOU CONTACT US!



***Review the following resources THOROUGHLY!***

[Student Compliance Webpage](#)

[Student Compliance Guide](#)

# WHO TO CONTACT?

## Admissions related Questions

**Admission Office**  
[admission@linfield.edu](mailto:admission@linfield.edu)

## Complio & Compliance Questions

**American Databank Complio**  
[complio@americandatabank.com](mailto:complio@americandatabank.com)

P: 800.200.0853

**School of Nursing**  
[schoolofnursing@linfield.edu](mailto:schoolofnursing@linfield.edu)

# DOCUMENTATION EXAMPLES

# BASIC LIFE SUPPORT

**BLS  
Provider**



**American  
Heart  
Association®**

**Jennifer Lawrence**

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

**Issue Date**

11/10/2018

**Recommended Renewal Date**

11/2020

**Training Center Name**

Inland Northwest Health Services

**Instructor Name**

Michael Brynjestad

**Training Center ID**

WA04012

**Instructor ID**

11110059908

**Training Center Address**

601 W 1st Ave  
Spokane WA 99201-3825 USA

**eCard Code**

185508110755

**Training Center Phone  
Number**

(509) 242-4264

**QR Code**



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to [www.heart.org/cpr/mycards](http://www.heart.org/cpr/mycards).

© 2016 American Heart Association. All rights reserved. 15-3001 3/16



Knowles, Beyonce | 09/04/1981 | MRN: 123456 | PCP: Suzanne L. Migchelbrink, MD

## QUANTIFERON - TB - Details

### Component Results

Component	Your Value	Standard Range
<b>QUANTIFERON</b>	<b>Your Value Negative</b>	<i>Standard Range Negative</i>
<p>This is a qualitative test. The IU/mL value should not be used to monitor disease progression or response to therapy. Data on the use of this test for children younger than 5 years of age is limited and Tuberculin Skin Test (TST) is the preferred test. Diagnosing or excluding tuberculosis disease, and assessing the probability of Latent tuberculosis infection, requires a combination of epidemiological, historical, medical, and diagnostic findings that should be taken into account when interpreting QuantiFERON-TB results. See general guidance on the diagnosis and treatment of TB disease and Latent tuberculosis infections (<a href="http://www.cdc.gov">www.cdc.gov</a>).</p>		
<b>QFT G INTERPRETATION</b>	<b>Your Value See Comment</b>	
<p>Mycobacterium tuberculosis infection unlikely but cannot be excluded, especially when illness is consistent with TB disease and likelihood of progression to TB disease is increased.</p>		
<b>TB 1 Antigen Minus NIL</b>	<b>Your Value &lt;0.13 IU/mL</b>	<i>Standard Range 0.00 - 0.34 IU/mL</i>
<b>TB 2 Antigen Minus NIL</b>	<b>Your Value &lt;0.13 IU/mL</b>	<i>Standard Range 0.00 - 0.34 IU/mL</i>

### General Information

Ordered by PROVIDENCE NEWBERG MED CENTER

Collected on 10/07/2019 3:17 PM (Blood)

Resulted on 10/09/2019 1:45 PM

Result Status: Final result



HEALTH EVALUATION FORM

Immunization Record

Name: Timberlake, Justin, Randall

DOB: 01/31/1981

A. ~~MMR #1 after first birthday~~  
~~MMR #2 after 1998~~

Date: 7/13/88  
Date: 5/12/92

OR MEASLES (Rubeola) - NOTE: TWO DOSES OF MEASLES VACCINE ARE REQUIRED. (If born before 1957, considered immune)

- 1. Dose 1 - Immunized with live measles vaccine after 1<sup>st</sup> Birthday
- 2. Dose 2 - Immunized after 1980

Date: 7/13/88  
Date: 5/12/92

OR

- 3. Antibody titer proving immunity. PROVIDE COPY OF REPORT

B. MUMPS - REQUIRED (If born before 1957, considered immune)

- 1. Immunized with vaccine after 1<sup>st</sup> birthday OR
- 2. Had disease, confirmed by office record OR
- 3. Antibody titer proving immunity. PROVIDE COPY OF REPORT

Date: 7/13/88  
Date: / /

C. RUBELLA

- 1. Immunized with vaccine after 1<sup>st</sup> birthday OR
- 2. Antibody titer proving immunity. PROVIDE COPY OF REPORT

Date: 7/13/88

D. TETANUS-DIPHTHERIA

- 1. Tetanus-diphtheria booster WITHIN THE LAST 10 YEARS - REQUIRED

Date: 3/10/05

E. POLIO - MINIMUM OF 3 DOSES IN ANY COMBINATION - REQUIRED

- 1. Dates of Primary Series
- 2. Date of last booster

#1 5/27/87 #2 7/22/87 #3 7/25/87 #4 11/1/88  
Date: / /

F. MENINGOCOCCAL VACCINE - REQUIRED - for all incoming students

- Review the enclosed information about risks and effectiveness
- Immunized with vaccine.

Date: 08/03/05

OR

- 2. Waiver form signed AND attached

Mary Williams LMB (ukrops) #487

G. HEPATITIS B - REQUIRED - for all incoming students

- Review the enclosed information about risks and effectiveness

- 1. Dose 1
- 2. Dose 2
- 3. Dose 3

Date: 1/27/99  
Date: 3/7/99  
Date: 5/26/99

OR

- 4. Waiver form signed AND attached

OR

- 5. Antibody titer proving immunity. PROVIDE COPY OF REPORT

H. VARICELLA VACCINE (Recommended if no history of disease)

- Has had disease OR
- 2. Dates of vaccine

Date: / / 1992  
Date: / /  
Date: / /

Colleague. Thank you for taking time to assist us with this important task. We know that vaccine preventable diseases occur on college campuses where students are not immunized or inadequately immunized. You help us to protect all students and their contacts BY NOT... by submitting immunization data from your office records or from records presented for your review which include... records are... in College of William and Mary.

Pediatric & Adolescent Medicine, L.L.P.  
3603 Grove Avenue  
Richmond, VA 23221  
(804)358-2361

DATE THIS FORM WAS COMPLETED

8/4/05

AN OFFICE STAMP MUST BE USED TO VALIDATE THIS FORM

Jeffrey S. Hartzel MD

SIGNATURE

Student Health Center

College of William and Mary P. O. Box 8795 Williamsburg, VA 23187-8795 757-221-4386 E-mail: sth@wm.edu



There needs to be month and date documented

# AFTER VISIT SUMMARY

Kaiser Permanente

1000 45th St, Oakland, CA 94612  
Tel: 415.833.8000 Fax: 415.833.8001

## Instructions



### Labels ordered today

HEPATIC INFECTION FOR TUBERCULOSIS  
Expires 1/1/2018  
Expires 8/1/2018

HEPATITIS B VIRUS SURFACE ANTIBODY  
Expires 1/1/2018  
Expires 8/1/2018

MELIUS IMMUNOGLOBULIN G  
Expires 1/1/2018  
Expires 8/1/2018

MUMPS VIRUS IMMUNOGLOBULIN G  
Expires 1/1/2018  
Expires 8/1/2018

RUBELLA IMMUNOGLOBULIN G  
Expires 1/1/2018  
Expires 8/1/2018

VARICELLA ZOSTER VIRUS IMMUNOGLOBULIN G  
Expires 1/1/2018  
Expires 8/1/2018

## What's Next

You currently have no upcoming appointments scheduled.

## Medications

A convenient way for getting your prescriptions filled

Skip the line and wait to wait.

If you don't need to start your medication today, you can save time and money by using our convenient Mail Order Pharmacy.

## Today's Visit

You saw Patrick L. Thompson, MD on Thursday, May 8, 2014. The following tests were ordered: ROUTINE ADULT HEALTH CHECK, UP/DOWN STAIRS, TESTING FOR ANTI-BOVINE RESPONSE, SCREENING FOR PULMONARY TUBERCULOSIS (BT OF THE LUNGS), and VACCINATION.

Blood Pressure  
124/62

BMI  
25.26

Weight  
178 lbs 8.6 oz  
(81 kg)

Height  
5' 10.5" (1.791 m)

Temperature (Oral)  
98.1 °F (36.7 °C)

Pulse  
68

Respiration  
14

Oxygen Saturation  
98%

Done Today  
VACCINE TETANUS,  
DIPHTHERIA



Not Legible



**Immunization Record  
Kaiser Permanente**

500 NE Multnomah Suite 100  
Portland, OR 97232

Name: Joe Jonas  
Address: 1234 Hollywood RD  
Portland, OR 97210

HRN: 23909182  
DOB: 08/15/1989  
Phone: 555-555-5555

SEX: Male

Immunization History

DPT, DTaP, DT, Td

1. 7/16/1992 DTP vaccine
2. 10/15/1992 DTP vaccine
3. 12/10/1992 DTP vaccine
4. 8/9/1994 DTP vaccine
5. 7/24/1997 DTAP
6. 2/19/09 TDAP (ADACEL)

Polio

1. 7/16/1992 OPV VACCINE
2. 10/15/1992 OPV VACCINE
3. 8/9/1994 OPV VACCINE
4. 7/24/1997 OPV VACCINE

Hib

1. 7/16/1992 HIB
2. 10/15/1992 HIB
3. 12/10/1992 HIB

Pneumococcal

MMR

1. 8/9/1994 MMR
2. 8/2/04 MMR

Varicella/Zoster

1. 8/2/04 VAR

Hepatitis A

1. 5/4/04 HAV
2. 2/19/09 HAV

Hepatitis B

1. 10/15/1992 HBV
2. 12/10/1992 HBV
3. 7/24/1997 HBV
4. 11/30/17 HBV (ADULT)
5. 1/8/18 HBV (ADULT)

HPV

1. 8/2/17 HPV9
2. 10/3/17 HPV9

Meningococcal

1. 7/17/15 MEN CONJ

Influenza

1. 11/28/16 INFS PF 4YRS+ (F)
2. 10/3/17 INFS PF 4YRS+ (FL)

Rotavirus

Other

PPD Skin

1. 10/20/08 TB-PPD
2. 10/27/08 TB-PPD
3. 4/17/12 TB-PPD
4. 6/7/13 TB-PPD
5. 7/13/15 TB-PPD
6. 9/29/15 TB-PPD
7. 10/3/17 TB-PPD
8. 10/18/17 TB-PPD

MT. SCOTT MEDICAL OFFICE  
9800 S.E. Sunnyside Rd.  
Clackamas, Oregon 97015  
INJECTION ROOM

JAN 08 2018

Medical History that affects immunity

VAR (Varicella, chickenpox)

HX OF VARICELLA [Z86.19]

10/20/2008 pt  
rpts hx of  
immunizations  
- no



## Test Results



Test: Varicella-Zoster V Ab, IgG  
Ordered By: Wajma Niazi, PA-C  
Ordered: 07/27/2019 Reported: 07/28/2019

Patient: Drew Berrymore  
Record ID: IF983763  
DOB: 08/21/1983

### Contact us:

tel: 1-844 ZOOM-777  
fax: 1-866 859-8195  
[www.zoomcare.com](http://www.zoomcare.com)  
[health@zoomcare.com](mailto:health@zoomcare.com)

## Your Results

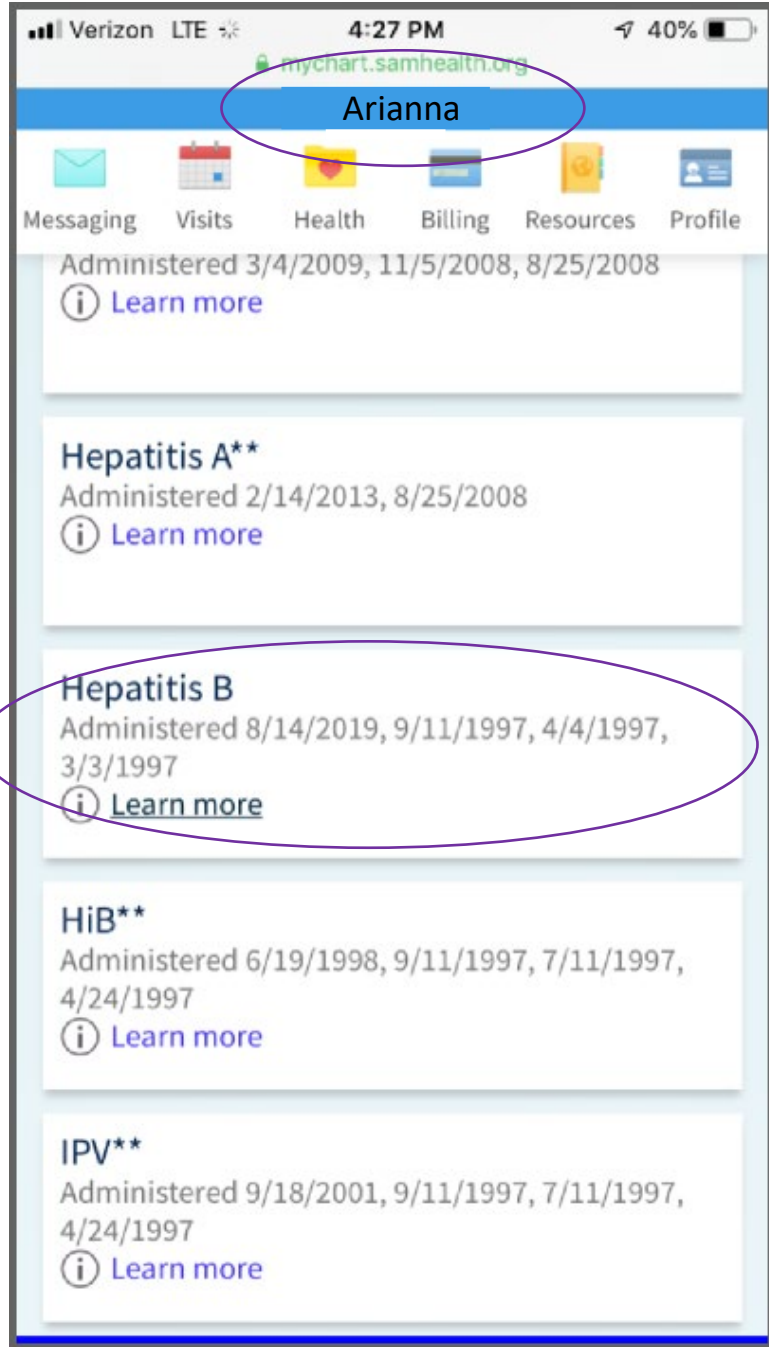
Test	Flag	Result	Reference Range	Units
Varicella Zoster IgG		2071	Immune >165	index

Negative <135 Equivocal 135 - 165 Positive >165 A positive result generally indicates exposure to the pathogen or administration of specific immunoglobulins, but it is not indication of active infection or stage of disease.

### Remarks

Labcorp Accession #: 20812911250 Testing performed at: [SE] LabCorp Seattle, 550 17th Avenue Ste 300, Seattle, WA, 98122-5789, Phone: 206-861-7000, Laboratory Director: Daniel L. Toweill, MD





No full legal name, DOB, Test Facility, or Provider Information

Name: Pedro Pascal | DOB: 8/23/1978 | MRN: 123456 | PCP: Theodor Seuss Geisel, MD

## TB TEST, CELL IMMUN MEASURE - Details

### Comments from the Doctor's Office

Quantiferon gold done and is negative for TB

### Component Results

Component	Your Value	Standard Range	Flag
<b>Reference Lab Component</b>	<b>See Reference Lab Report</b>		
<b>QuantIFERON Incubation</b>	<b>Incubation performed.</b>		
<b>QuantIFERON Criteria</b>	<b>Comment</b>		
	QuantiFERON-TB Gold Plus is a qualitative indirect test for M tuberculosis infection (including disease) and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations. The QuantiFERON-TB Gold Plus result is determined by subtracting the Nil value from either TB antigen (Ag) value. The Mitogen tube serves as a control for the test.		
<b>QuantIFERON TB Ag Value</b>	0.00 IU/mL	IU/mL	
<b>QuantIFERON TB2 Ag Value</b>	0.00 IU/mL	IU/mL	
<b>QuantIFERON Nil Value</b>	0.00 IU/mL	IU/mL	
<b>QuantIFERON Mitogen Value</b>	>10.00 IU/mL	IU/mL	
<b>QFTBGP</b>	<b>Negative</b>	Negative	
	No response to M tuberculosis antigens detected. Infection with M tuberculosis is unlikely, but high risk individuals should be considered for additional testing (ATS/IDSA/CDC Clinical Practice Guidelines, 2017). The reference range is an Antigen minus Nil result of <0.35 IU/mL. Chemiluminescence immunoassay methodology		



Missing when the test was conducted

---

**MMR (Measles, Mumps,  
Rubella)** 09/17/03

---

**MMR (Measles, Mumps,  
Rubella)** 08/24/00



# **CLINICAL PREPARATION**

# HEALTH PASSPORT

You are expected to keep a paper compliance report (i.e., Health Passport) behind your Linfield badge

**Username:** Immunization/Compliance  
Linfield University BSN

**Institute:** Linfield University

**Overall Compliance Status** **Compliant** (14/14 Compliant)

**Applicant Name:**

Compliance Category/Item (Expand / Collapse) Requirement Explanation

**Keep your Health Passport Updated**

1. Log into American Databank Compliant
2. Click on Report
3. Export your summary
4. Open your download and trim to fit behind your ID badge

Report

Category	Category Status	Non-Compliance Date	Requirement	Date	Results	Expiration Date	Compliance Status
MMR	Approved	✓	MMR Dose 1	08/13/2001			Meets
			MMR Dose 2	08/12/2004			Meets
			Measles Titer				Incomplete
			Mumps Titer				Incomplete
			Rubella Titer				Incomplete
			Post-Titer MMR Booster 1				Incomplete
Varicella	Approved	✓	Varicella Dose 1	08/13/2001			Meets
			Varicella Dose 2	07/21/2008			Meets
			Varicella Titer				Incomplete
			Varicella Disease Date				Incomplete
Hepatitis B	Approved	✓	02/14/2021				
			Hepatitis B Dose 1	02/13/2001			Meets
			Hepatitis B Dose 2	08/13/2001			Meets
			Hepatitis B Dose 3	02/11/2002			Meets
			Hepatitis B (HbsAB) Titer	06/16/2020	Negative		Meets
			Post-Titer Hepatitis B Booster	06/24/2020			Meets
			Post-Titer Hepatitis B Booster	08/13/2020			Meets
			Post-Titer Hepatitis B Booster				Incomplete
Hepatitis B (HbsAB) Repeat				Incomplete			
Tuberculosis	Approved	✓	06/30/2021				
			PPD Step 1 of 2	06/16/2020	Negative		Meets
			PPD Step 2 of 2				Incomplete
			Initial QuantiFERON TB Test / T-	06/29/2020	Negative		Meets
			Annual PPD				Incomplete
			Annual QuantiFERON TB Test /				Incomplete
			Chest X-Ray				Incomplete
			TB Screening Review				Incomplete
Tetanus, Diphtheria, Pertussis (Tdap)	Approved	✓	06/16/2030				
			Initial Tdap	11/21/2011			Meets
Influenza	Approved	✓	11/01/2021				
			TD Booster			06/16/2030	Meets
			Flu Vaccine	10/05/2020		11/01/2021	Meets
BLS Certification	Approved	✓	05/31/2022				
			Flu Declination				Incomplete
Health Assessment	Approved	✓	05/31/2022	05/21/2020		05/31/2022	Meets
Essential Functions	Approved	✓					Meets
Health Insurance	Approved	✓		06/10/2020			Meets
COVID-19	Approved	0	Swab Test				Incomplete
			Antibody Test				Incomplete
			COVID-19 Dose 1				Meets
			COVID-19 Dose 2				Meets
Background Check	Approved	✓		06/11/2020	Clear		Meets
Drug Screening	Approved	✓		07/01/2020	Clear		Meets