College of the Mainland

Continuing Education: Allied Health Programs

Student Requirements

Desired Class Date _____ CEQ _____ Name _____ Address _____ City _____ Zip _____ Phone _____ Alt Phone _____ Email _____	**STAFF VERIFICATION:** _____ **DATE:** _____ **COMMENTS:** _____ _____ _____

PROGRAM (check one):

☐ Dental Assistant ☐ Patient Care Technician

☐ Electrocardiography Technician ☐ Phlebotomy Technician

Dental Assistant:

- High School Diploma or GED copy
- Required Immunizations document signed and dated by your Healthcare Provider and accompanying shot records **must** include:
  - ***Hepatitis B (3 shots)***
  - ***TB Skin Test Negative (within 12 months)***
  - ***10 Panel Drug Screen Test Negative (within 12 months)***
- Student Acknowledgement of Hepatitis B Vaccine
- Current COM Healthcare Physical document signed and dated by your Healthcare Provider (no older than 12 months)
- Criminal History/Background Check (Instructions attached) (no older than 12 months)
- Copy of Social Security Card (MUST match Photo ID)
- Copy of Driver's License or Government Issued Photo ID (MUST match Social Security Card) ***[Expired ID will not be accepted]***

This course trains students for employment as a dental assistant and prepares them to take the State of Texas Registered Dental Assistant (RDA) exam. To register for this exam, students must also complete an online course, costing approximately $155. Additional fees payable to the State of Texas will include a $36 application fee, $150 state test fee & other associated fees. These requirements will be discussed at the first class meeting.

Patient Care Technician:

- High School Diploma or GED copy
- **Must** have completed the following courses:
  - Certified Nurse Aide (CNA)
  - Electrocardiography Tech (ECG)
  - Phlebotomy
- Criminal History/Background Check (Instructions attached)
- Valid AHA CPR for Healthcare Providers Certification/Card
- Copy of Social Security Card (MUST match Photo ID)
- Copy of Driver's License or Government Issued Photo ID (MUST match Social Security Card) ***[Expired ID will not be accepted]***

This course prepares students for a job as a patient care technician, who performs a role similar to that of a certified nurse assistant but with more responsibility. Patient care techs acquire patient vital signs, gather blood samples and are a key member of the medical team.

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CE Allied Health 200 Parker Court League City, Texas 77573 409-933-8645

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Electrocardiography (ECG)/Telemetry Technician:

- High School Diploma or GED copy
- Required Immunizations document signed and dated by your Healthcare Provider and accompanying shot records **must** include:
  - ***Hepatitis B (3 shots)***
  - ***Tdap (within the last 10 years)***
  - ***MMR (2 shots)/TITER***
  - ***Varicella (2 shots)/TITER***
  - ***TB Skin Test Negative (within 12 months)***
  - ***10 Panel Drug Screen Test Negative (within 12 months)***
- Student Acknowledgement of Hepatitis B Vaccine
- Documenting History of Varicella form
- Current COM Healthcare Physical document signed and dated by your Healthcare Provider (no older than 12 months)
- Criminal History/Background Check (Instructions attached) (no older than 12 months)
- Copy of Social Security Card (MUST match Photo ID)
- Copy of Driver's License or Government Issued Photo ID (MUST match Social Security Card) ***[Expired ID will not be accepted]***

This course provides an overview of basic cardiovascular terminology, anatomy and physiology. It focuses on the proper placement of ECG leads and maintenance of equipment to obtain an accurate 12-lead ECG. Students will learn to recognize cardiac arrhythmias. The course outlines responsibilities of ECG technicians and provides clinical laboratory opportunity to develop entry-level skills.

- *Seasonal Flu Vaccine may be required by clinical/extern site. Requirement will be discussed in class.*

Phlebotomy Technician:

- Must have High School Diploma or GED copy
- Required Immunizations document signed and dated by your Healthcare Provider and accompanying shot records **must** include:
  - ***Hepatitis B (3 shots)***
  - ***Tdap (within the last 10 years)***
  - ***MMR (2 shots)/TITER***
  - ***Varicella (2 shots)/TITER***
  - ***TB Skin Test Negative (within 12 months)***
  - ***10 Panel Drug Screen Test Negative (within 12 months)***
- Student Acknowledgement of Hepatitis B Vaccine
- Documenting History of Varicella form
- Current COM Healthcare Physical document signed and dated by your Healthcare Provider (no older than 12 months)
- Criminal History/Background Check (Instructions attached) (no older than 12 months)
- Copy of Social Security Card (MUST match Photo ID)
- Copy of Driver's License or Government Issued Photo ID (MUST match Social Security Card) ***[Expired ID will not be accepted]***

This course trains students in the safest methods of drawing blood with as little patient discomfort as possible. Students are introduced to basic knowledge and skills of the phlebotomy profession. Students will learn various types of blood collections utilizing the proper techniques and universal precautions. On completion of the course, a National Healthcare Association CPT exam will be administered.

- *Seasonal Flu Vaccine may be required by clinical/extern site. Requirement will be discussed in class.*

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Physical Exam & Immunization Requirements

Student's Name

Last	M/I	First		Sex	DOB: (DD/MM/YYYY) / /
Weight	Height	Pulse	Temp	Blood Pressure S _____ D _____	

List any current illnesses or injuries:_____

List any permanent medical conditions or physical limitations:_____

Medical History: *(Check if applicable)*

☐ Asthma	☐ Heart Disease	☐ Tuberculosis	☐ Measles
☐ Diabetes	☐ Seizures	☐ Emphysema	☐ Hypoglycemic
☐ Hepatitis	☐ Rheumatism	☐ Small Pox	☐ Tuberculosis
☐ Diphtheria	☐ Influenza	☐ Pneumonia	☐ Infantile Paralysis
☐ Osteoarthritis	☐ Mumps	☐ Other _____ (Please specify)	

(If checked above please explain): _____

_____

Tests:

(Please attach proof of results. Must be no more than 1 year old to the date of the class. If results are positive, a chest x-ray is required)

TB Skin Test ☐ Pos ☐ Neg	Date read	Initials	**TB Chest X-ray** ☐ Pos ☐ Neg	Date read	Initials

(*Attach proof of finding)

Immunizations (Give most recent date)

Hepatitis B (3 shots) 1._____ 2._____ 3._____	Tdap (w/in last 10 yrs)	MMR (2 shots)	Varicella (2 shots)/Titer	Seasonal Flu

I certify that I have examined this individual and he/she is suitable physically and emotionally for the College of the Mainland Allied Health Program to which they are applying for:

☐ Yes ☐ No (If no, please explain) _____

_____

_____ _____ M.D.

Date: Signature

_____

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Address

Background Check

A background check from the Texas Department of Public Safety is required to be presented by the student for COM's Continuing Education Allied Health programs. Please go to the Texas Department of Public Safety website at **www.txdps.state.tx.us** to obtain instructions on how to request a criminal history check. The approximate cost for getting a background check is $3.57 for each last name of applicant. This must be turned in with checklist information required for your desired program. **Background checks older than 12 months to the class date you are applying for will not be accepted.**

Release Agreement

I hereby release and discharge College of the Mainland and all its employees from all liability for all injury, exposure or damage arising from health risks during my clinical rotation or during scheduled class or skills lab. I understand that I may be exposed to communicable diseases *(including blood-borne pathogens)* or personal injury.
Please initial._____

I am also aware that the College of the Mainland Allied Health Department requires that I have the required immunizations before my clinicals. I understand that I will not be allowed to enter the clinic facility for clinical purposes if I do not have the required immunizations. *Please initial.*_____

Applicant's Statement

I certify that I have read the above statements and that initialing my name means that I agree with the above statements. If accepted into the College of the Mainland Allied Health Program, I agree to abide by the rules set forth by the school and the program.

Student Signature: _____ Date: _____

Student Printed Name: _____

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STUDENT ACKNOWLEDGEMENT OF HEPATITIS B VACCINE

Department of State Health Services
Disease Prevention & Intervention Section
Immunization Branch

POLICY STATEMENT 1.0 Completion of Hepatitis B vaccine series prior to direct patient care

The Texas Department of State Health Services (DSHS) rule §97.64, "Required Vaccinations for Students Enrolled in Health-Related and Veterinary Courses in Institutions of Higher Education" [25TAC§97.64, April 2004], requires students enrolled in health-related courses, which will involve direct patient contact in medical or dental care facilities to **complete a three dose series of hepatitis B vaccine prior to direct patient care**. This rule applies to all medical interns, residents, fellows, nursing students, and others who are being trained in medical schools, hospitals, and health science centers and students attending two-year and four-year colleges whose course work involves direct patient contact regardless of the number of courses taken, number of hours taken, and the classification of student.

Website for Texas Department of State Health Services Adult Immunizations Schedule:
http://www.dshs.state.tx.us/immunize/adult_sched.shtm

Please check one of the following boxes as it applies to your Hepatitis B series:

☐ I have completed the Hepatitis B 3 shot series

☐ I only have 1 shot remaining of the 3 shot series: 3rd shot due _____

☐ I have completed my first shot and the dates for the next two shots are:
_____ and _____

☐ ***Based upon the clinical/extern site rules and regulations I understand & acknowledge that if I have not completed the Hepatitis B 3 shot series, I may not be able to participate in the clinical/externship portion of the program.***

☐ I have read and understand the Texas Department of State Health Services policy on Hepatitis B vaccine series. https://www.dshs.state.tx.us/immunize/docs/school/hepB_Policy.pdf

_____
Student Printed Name

X_____ Date: _____
Student Signature

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Documenting History of Illness: Varicella (Chickenpox)

This form summarizes the "**Exceptions to Immunization Requirements (Verification of Immunity/History of Illness) for Varicella (Chickenpox)**."

A written statement from a parent (or legal guardian or managing conservator), or physician attesting to the student's positive history of varicella disease (chickenpox), or of varicella immunity, is acceptable in lieu of a vaccine record for that disease. College of the Mainland shall accurately record the existence of any statements attesting to previous varicella illness or the results of any serologic tests supplied as proof of immunity. If a student is unable to submit such a statement or serologic evidence, varicella vaccine is required.

Documentation of prior varicella illness can be provided by the following methods:

1. A serologic confirmation of varicella immunity (positive varicella IgG result).

2. A written statement from a physician or the student's parent or guardian containing wording such as: "This is to verify _____had varicella
(Name of Student)
disease (chickenpox) on or about _____ and does not need
(Approximate month/year)
the varicella vaccine."

_____ _____
(Printed name of person completing form) (Signature of person completing form)

_____ _____
(Relationship to student) (Date)

TEXAS Department of State Health Services

For more information about
Varicella contact:
Texas Department of State
Health Services
Immunization Branch
(800) 252-9152
www.ImmunizeTexas.com

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