Student Requirements

<table>
<thead>
<tr>
<th>Desired Class</th>
<th>Date</th>
<th>CEQ</th>
<th>STAFF VERIFICATION:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<th>Address</th>
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<thead>
<tr>
<th>City</th>
<th>Zip</th>
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<tr>
<th>Phone</th>
<th>Alt Phone</th>
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<tr>
<th>Email</th>
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<tr>
<th>PROGRAM (check one):</th>
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</thead>
<tbody>
<tr>
<td>□ Dental Assistant</td>
</tr>
<tr>
<td>□ Patient Care Technician</td>
</tr>
<tr>
<td>□ Electrocardiography Technician</td>
</tr>
<tr>
<td>□ Phlebotomy Technician</td>
</tr>
</tbody>
</table>

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 1 year)**
- Student Acknowledgement of Hepatitis B Vaccine
- Current Healthcare Physical document signed and dated by your Healthcare Provider (no older than 3 months)
- Criminal History/Background Check (Instructions attached)
- 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**]

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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<table>
<thead>
<tr>
<th>Electrocardiography (ECG)/Telemetry Technician:</th>
<th>Phlebotomy Technician:</th>
</tr>
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<tbody>
<tr>
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<tr>
<td><strong>Hepatitis B (3 shots)</strong></td>
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</tr>
<tr>
<td><strong>Tdap (within the last 10 years)</strong></td>
<td><strong>Tdap (within the last 10 years)</strong></td>
</tr>
<tr>
<td><strong>MMR (2 shots)/TITER</strong></td>
<td><strong>MMR (2 shots)/TITER</strong></td>
</tr>
<tr>
<td><em><em>Varicella</em> (2 shots)/TITER</em>*</td>
<td><em><em>Varicella</em> (2 shots)/TITER</em>*</td>
</tr>
<tr>
<td><strong>TB Skin Test Negative (within 1 year)</strong></td>
<td><strong>TB Skin Test Negative (within 1 year)</strong></td>
</tr>
<tr>
<td>Student Acknowledgement of Hepatitis B Vaccine</td>
<td>Student Acknowledgement of Hepatitis B Vaccine</td>
</tr>
<tr>
<td>Documenting History of Varicella form*</td>
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</tr>
<tr>
<td>Current Healthcare Physical document signed and dated by your Healthcare Provider (no older than 3 months)</td>
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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.

**There will be an additional approximate expense of $35 for a 10 panel drug screening**

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

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.

**There will be an additional approximate expense of $35 for a 10 panel drug screening**

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

For more information: Contact Nichole Sullivan, Administrative Assistant, 409-933-8645, nsullivan1@com.edu

Revised April 27, 2015
Physical Exam & Immunization Requirements

Student’s Name

<table>
<thead>
<tr>
<th>Last</th>
<th>M/I</th>
<th>First</th>
<th>Sex</th>
<th>DOB: (DD/MM/YYYY)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>Pulse</th>
<th>Temp</th>
<th>Blood Pressure</th>
</tr>
</thead>
</table>

DOB: / /

List any current illnesses or injuries: ____________________________________________

List any permanent medical conditions or physical limitations: __________________________

Medical History: (Check if applicable)

- □ Asthma
- □ Diabetes
- □ Heart Disease
- □ Seizures
- □ Hepatitis
- □ Rheumatism
- □ Tuberculosis
- □ Emphysema
- □ Small Pox
- □ Hypoglycemic
- □ Measles
- □ Tuberculosis
- □ Infantile Paralysis
- □ Diabetes
- □ Seizures
- □ Emphysema
- □ Small Pox
- □ Tuberculosis
- □ Hepatitis
- □ Rheumatism
- □ Asthma
- □ Diabetes
- □ Heart Disease
- □ Seizures
- □ Rheumatism
- □ Hypoglycemic
- □ Measles
- □ Tuberculosis
- □ Infantile Paralysis
- □ Tuberculosis
- □ Small Pox
- □ Childbirth
- □ 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)

<table>
<thead>
<tr>
<th>TB Skin Test</th>
<th>Date read</th>
<th>Initials</th>
<th>TB Chest X-ray</th>
<th>Date read</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Pos</td>
<td>□ Neg</td>
<td></td>
<td>□ Pos</td>
<td>□ Neg</td>
<td></td>
</tr>
</tbody>
</table>

(*Attach proof of finding)

Immunizations (Give most recent date)

<table>
<thead>
<tr>
<th>Hepatitis B (3 shots)</th>
<th>Tdap (w/in last 10 yrs)</th>
<th>MMR (2 shots)</th>
<th>Varicella (2 shots)/Titer</th>
<th>Seasonal Flu</th>
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<tr>
<td>1. _____________________</td>
<td>Tdap (w/in last 10 yrs)</td>
<td>MMR (2 shots)</td>
<td>Varicella (2 shots)/Titer</td>
<td>Seasonal Flu</td>
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<td>2. _____________________</td>
<td>Tdap (w/in last 10 yrs)</td>
<td>MMR (2 shots)</td>
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<td>Seasonal Flu</td>
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<tr>
<td>3. _____________________</td>
<td>Tdap (w/in last 10 yrs)</td>
<td>MMR (2 shots)</td>
<td>Varicella (2 shots)/Titer</td>
<td>Seasonal Flu</td>
</tr>
</tbody>
</table>

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: _______________________

Address: ________________________

Revised April 27, 2015
**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](http://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 2 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: _____________________________
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

Revised April 27, 2015
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)

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

Revised April 27, 2015