** Clinical Training Requirements Checklist for Conditionally Accepted 2016-17 Allied Health Students**

The following checklist outlines required documentation for conditionally accepted 2016-17 Allied Health students. Please read this carefully.

**Failure to comply with the submission of any of these documents will result in a denial of participation in clinical training**

____ Criminal Background Check **AND** 12-Panel Urine Drug Screen

Davidson County Community College has partnered with Verified Credentials, Inc. to help you supply the required documentation for your program. Please follow these steps:

1. Please select a code from the table below that corresponds with your program of study.
2. Access the following link to get started: [http://scholar.verifiedcredentials.com/davidsonccc](http://scholar.verifiedcredentials.com/davidsonccc)
3. Enter your code
4. Create an account
5. Review the required information (you can use this checklist as a guide)
6. Enter the required information
7. Scan and upload the supporting documentation

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Information Mgmt</td>
<td>RTYPY-89792</td>
</tr>
<tr>
<td>Central Sterile Processing</td>
<td>RTHJP-74466</td>
</tr>
<tr>
<td>Healthcare Interpreting</td>
<td>WXFDW-93384</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>DFCYJ-32948</td>
</tr>
<tr>
<td>Medical Assisting</td>
<td>YYBXT-92978</td>
</tr>
<tr>
<td>Medical Laboratory Technology</td>
<td>YYGMX-93694</td>
</tr>
<tr>
<td>Nurse Aide CU (NAS)</td>
<td>VWJTP-86778 (Davidson Campus); BBRMP-27672 (Davie Campus)</td>
</tr>
<tr>
<td>Pharmacy Technology</td>
<td>JJWVK-69864</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>MMBCK-62267 (Davidson Campus); BBTCX-28292 (Davie Campus)</td>
</tr>
<tr>
<td>Surgical Technology</td>
<td>PRXXM-79966</td>
</tr>
</tbody>
</table>

For customer service or technical assistance, please call (800)473-4934. For best results, use a laptop or desktop computer to complete this process.

**PLEASE NOTE: IT IS EACH STUDENT’S RESPONSIBILITY TO COMPLETE AND PAY FOR THIS PROCESS AND FOLLOW UP WITH VERIFIED CREDENTIALS, INC. IF NECESSARY.**

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Please direct any questions regarding health information documentation to:

Nancy Harrison, Clinical Coordinator
Davidson County Community College
(336)249-8186 x6180
nancy_harrison@davidsonccc.edu

Briggs Technology Building
P.O. Box 1287/Lexington, NC 27293
(336)249-9060 fax
Do not send any documentation to Admissions. It is strongly recommended to send all of these materials well in advance of any deadlines so that any omissions or incomplete records may be corrected.

Checklist of Documentation (please refer to shaded chart below for due dates)

- Health Form  **PLEASE NOTE: A PHYSICAL EXAMINATION IS NOT REQUIRED.**  
  **Surgical Technology** students are required to have an eye exam**

PLEASE COMPLETE THESE FORMS CAREFULLY & COMPLETELY, KEEP A COPY, AND UPLOAD DOCUMENTS INTO VERIFIED CREDENTIALS ACCOUNT. North Carolina laws and Davidson County Community College policy require documentation of immunization information. Any and all attachments to these forms should include your name and DCCC student ID number for identification purposes.

- **Report of Medical History, Family & Personal Health History** - to be completed by student AND if under 18 years of age, also signed by parent/guardian.

- **Immunization Record** (documentation for immunizations can be on provided on the enclosed health form or on another form signed or stamped by a clinical agency). All documentation must include an authorized signature or clinic stamp.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>For 2016-2017 academic year, if student will be in.....</th>
<th>Then, all documentation is DUE on the following dates.....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Information Mgmt</td>
<td>Second year of program</td>
<td>7/5/16</td>
</tr>
<tr>
<td>Central Sterile Processing</td>
<td>First year of program</td>
<td>7/14/16</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>First year of program</td>
<td>7/5/16</td>
</tr>
<tr>
<td>Medical Assisting</td>
<td>First year of program</td>
<td>3/15/17</td>
</tr>
<tr>
<td>Medical Laboratory Technology</td>
<td>First year of program</td>
<td>5/1/17</td>
</tr>
<tr>
<td>Nurse Aide CU (NAS)</td>
<td>First year of program</td>
<td>2016FA – 6/1/16; 2017SP – 10/3/16</td>
</tr>
<tr>
<td>Pharmacy Technology</td>
<td>First year of program</td>
<td>7/14/16</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>First year of program</td>
<td>at the time of registration</td>
</tr>
<tr>
<td>Surgical Technology</td>
<td>First year of program</td>
<td>7/14/16</td>
</tr>
</tbody>
</table>

- Documentation needed for this section is for the immunizations listed below only.

- Tetanus/Diphtheria/Pertussis (Tdap) Vaccination
  Documentation of a Tdap vaccination within the last 10 years is required

- Two-Step Tuberculin Skin Test (TST)* - form on page 7, if needed
  **Step One:** First test to be administered and initial result to be read by trained healthcare professional within 48 to 72 hours.
  If result is positive: TB questionnaire & chest x-ray within 5 years required.
  If result is negative: Proceed with Step Two:

  **Step Two:** Second test to be administered in 1 to 3 weeks of first test.
  If second test result is positive: TB questionnaire & chest x-ray within 5 years required. *if updated annually on or before the result date of second TB test as noted above, only one TB test with result will be needed; if that date is exceeded, a 2-step TB test will need to be repeated
____ MMR (Measles, Mumps, Rubella) Vaccinations: 2 doses, 4 weeks apart OR positive serum titers for each disease. PLEASE NOTE: You must provide evidence of immunity by serum titers or proof of 2 doses of live measles, 2 doses of live mumps and at least 1 dose of live rubella. Single doses of measles and mumps vaccines are not sufficient. History of disease, even from a physician, is not acceptable.

____ Hepatitis B Vaccinations: 3 doses over a 6-month period
Dose #2 one month after dose #1, dose #3 approx. 5 months after #2.
PLEASE NOTE: The first two doses are required by the posted deadline.

____ Chickenpox (Varicella) Vaccinations: 2 doses, 4 weeks apart OR positive serum titer. PLEASE NOTE: History of disease, even from a physician, is not acceptable.

____ Annual Seasonal Influenza Vaccination (available each fall)
Please check with program contact to confirm the type of flu shot that is required for the current flu season.

- Physical Examination: Not required

____ Statement of Policy Regarding Clinical Training
Be sure you read and understand the DCCC policies regarding placement for clinical training. Please complete the attached form (pages 4-5).

____ Statement of Understanding Regarding Seasonal Influenza Vaccination
An annual seasonal flu vaccination is required every fall. Please complete the statement of understanding form (page 6).

____ Basic Life Support (CPR) Certification for the Healthcare Provider*
*Central Sterile Processing, Medical Assisting, Nursing, and Surgical Technology students ONLY

Training must include 1-man and 2-man CPR for adult, child and infant. Only American Heart Association CPR training is acceptable. Provide front and signed back copy of CPR certification card.

*Although not currently a requirement, each Pharmacy Technology student should be aware of occasions when emergencies arise and how pharmacy technicians can assist pharmacists by being certified as a Basic Life Support (BLS) Health Provider.

NOTE: The student is also expected to create and maintain a portfolio of the documents listed above and may be asked to provide copies of certain documentation at clinical sites.
DAVIDSON COUNTY COMMUNITY COLLEGE

STATEMENT OF POLICY REGARDING CLINICAL TRAINING IN THE FOLLOWING PROGRAMS

Associate Degree Nursing  Cancer Information Management
Central Sterile Processing  Emergency Medical Science
Health Information Technology  LPN-to-ADN Option
Medical Assisting  Medical Laboratory Technology
Nurse Aide  Pharmacy Technology
Phlebotomy  Practical Nursing Education
Surgical Technology

Students accepted into the above programs must meet the standards of both the College and the contracting clinical site in order to participate in the appropriate clinical training for the program. Each clinical site where a student receives training reserves the right to refuse clinical training to any student found to be unacceptable according to that site’s policies and regulations. Reasons for refusal could include, among other considerations, a positive drug screen, an incomplete immunization record, a documented police record indicating convictions for drug or alcohol related charges, child abuse or molestation, burglary, larceny or other convictions deemed inappropriate to the particular clinical setting. Clinical sites require a law enforcement record check prior to a student’s placement for training at that site. Convictions for certain crimes and/or evidence of drug use may disqualify students from participating in clinical experiences. Although an applicant’s criminal background will not prohibit admission to the college or a health sciences program, the inability to participate in clinical experiences would prohibit the student from progressing and completing the program successfully. No applicant shall be denied admission to clinical training due to age, gender, race, religion, national origin or handicap.

The student must conform to, and be subject to, all policies and regulations of the assigned clinical site. The site reserves the right to end clinical training of any student found violating rules, policies or procedures. This suspension of clinical training can only follow consultation between personnel at the clinical site and college personnel. Written justification must be provided for such suspension. The clinical site and college personnel reserve the right to take appropriate immediate action when necessary to maintain the proper and safe operation of its facilities and the safety of clients in the clinical site.

Students in clinical training sites who exhibit impaired job performance or impaired thinking (the inability to make appropriate judgments and/or to carry out functions appropriately) or who exhibit other signs of possible use of alcohol or controlled substances may be requested to provide a urine or blood sample for testing in order to determine whether or not there has been use of drugs or alcohol. Failure to provide body fluid samples will be interpreted as supportive of impairment. Test results indicating use of controlled substances or alcoholic beverages will be grounds for suspension from the program.
STATEMENT OF UNDERSTANDING REGARDING CLINICAL TRAINING

I verify that I have read and understand the policies of Davidson County Community College regarding placement for clinical training. I understand that conviction for certain crimes under the law, positive drug screen results, or incomplete immunization records may prevent my ability to obtain clinical training, licensure and/or employment. I also understand that the inability to participate in clinical experiences would prohibit the progression and successful completion of the program.

I understand that it is a privilege to be accepted as a student in these above programs of study and that the sensitive nature of the programs require that students participating in clinical practice should be free from any controlled substances which might impair the abilities of the student to perform his or her duties in such a setting. This is true whether the substances are prescribed or not.

In view of the foregoing, I affirm that I do not currently use any illegal drugs; nor do I abuse alcohol or prescribed or non-prescribed medications.

During my clinical practice involvement as a student at Davidson County Community College, I agree to voluntarily give body fluid samples should the instructor or manager of the clinical unit where I am assigned so request on the basis of impaired job performance. I understand and agree that refusal to provide samples, when requested, will make me subject to disciplinary actions as provided in the rules and regulations of the College. This could result in suspension from the program. I further agree that the College shall be relieved from any liability and cost associated with the taking and testing of samples of my body fluids which shall be done by independent medical or laboratory personnel.

FURTHERMORE, I authorize the release of the results of these tests, examinations, and health records to the designated Davidson County Community College representatives and affiliated sites. By this authorization I do hereby release the previously designated doctors, medical personnel or employees of the College and clinical agency from any and all liabilities arising from the release or use of the information derived from or contained in my physical examination and test results.

I also authorize Davidson County Community College and affiliated sites to conduct any investigation of law enforcement records necessary and pertinent to placement with a clinical training site.

I verify that I have read and fully understand the foregoing statement prior to my admission into the program and that I have executed this agreement of my own free will and volition without any compulsion or coercion whatsoever.

Signature _____________________
Print Name ___________________
Date ________________
DAVIDSON COUNTY COMMUNITY COLLEGE
STATEMENT OF UNDERSTANDING REGARDING SEASONAL INFLUENZA VACCINE

NAME:______________________________________________

Program (please check appropriate box below):

☐ Associate Degree Nursing ☐ Cancer Information Management
☐ Central Sterile Processing ☐ Emergency Medical Science
☐ Health Information Technology ☐ LPN-to-ADN Option
☐ Medical Assisting ☐ Medical Laboratory Technology
☐ Nurse Aide ☐ Pharmacy Technology
☐ Phlebotomy ☐ Practical Nursing Education
☐ Surgical Technology

Please sign below. Your signature indicates your understanding of the flu vaccine requirements.

CONSENT

I understand that I will be required to take this vaccine annually upon its availability in the fall. I understand that, as with all medical treatment, there is no guarantee that I will develop immunity or that I will not experience an adverse effect from the vaccine. I understand that I will be responsible for the cost of the vaccine. I will maintain this documentation in my personal records and turn in copies to the College.

Signature: ______________________________ Date:_____________________

Signature: ______________________________ Date:_____________________
TUBERCULOSIS SYMPTOM SCREEN QUESTIONNAIRE & SKIN TESTING FORM

Please complete the following questionnaire:

Do you have:
- Unexplained productive cough?  Yes  No
- Unexplained weight loss?  Yes  No
- Unexplained appetite loss?  Yes  No
- Unexplained fever?  Yes  No
- Night sweats?  Yes  No
- Shortness of breath?  Yes  No
- Chest pain?  Yes  No
- Increased fatigue?  Yes  No

If you circled ‘yes’ for any of the above symptoms, please provide an explanation below:

____________________________________________________________________________________

If you have ever had a positive TB skin test?  Yes  No

If yes, please attach documentation of chest x-ray results (within the last 5 years).

TWO-STEP TB TEST

FIRST STEP
Annual screening:

Manufacturer: ______________________ Lot #: ______________________  Expiration date: ____________
Date given: ______________ Location administered: ______________ Administered by: ______________
Date read: ______________ Read by: ________________ Results: ______________ mm

SECOND STEP (1 – 3 weeks after first step)
Annual screening:

Manufacturer: ______________________ Lot #: ______________________  Expiration date: ____________
Date given: ______________ Location administered: ______________ Administered by: ______________
Date read: ______________ Read by: ________________ Results: ______________ mm

By signing this form, I certify that the above information is accurate to the best of my knowledge. I will seek medical attention immediately if symptoms change and/or a subsequent x-ray is recommended by a clinician.

Student Signature: ___________________________________________ Date: ______________________

Please print name: ____________________________________________

Provider Signature: ___________________________________________ Date: ______________________

Provider Address: _____________________________________________ Phone: ______________________