** Clinical Training Requirements Checklist for Conditionally Accepted 2017-18 EMS Students**

The following checklist outlines required documentation for conditionally accepted 2016-17 EMS and Paramedic 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

Please complete the attached Authorization for Release of Information & Records (page 2) for submission directly to Investigative Associates & Consultants (IAC). You may mail, email, fax or deliver your release in person. Once submitted, IAC will contact you to discuss payment options. The fee varies depending on how many names and addresses are listed on your Social Security trace. Acceptable forms of payment are cash, personal check or money order. Once payment is made, you will receive the form for your drug screening. The drug screening can be done at IAC. For additional lab locations please consult with representatives at IAC. You must advise IAC of which location you intend to use for your drug screen in order to receive the appropriate form. You should complete the drug screening within 3 days of receiving the form. **Deadline for payment to IAC will be the same as the documentation due date noted for each program in the table on page 3.**

Please check your DCCC email regularly for updates and additional information.

For further information or questions, please contact Investigative Associates & Consultants directly. **PLEASE NOTE: IT IS EACH STUDENT’S RESPONSIBILITY TO COMPLETE THIS PROCESS AND FOLLOW UP WITH IAC IF NECESSARY.**

Investigative Associates & Consultants
3796 Vest Mill Road
Winston-Salem, NC 27103
info@iacinvestigations.com
(336) 768-7040

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Please direct any questions regarding health information documentation to:

Wendy Bundy, EMS Clinical Coordinator
Public Safety Services Building, #125
Davidson County Community College
P.O. Box 1287/Lexington, NC 27293
(336)224-4665 FAX(336)249-9053
wbundy6725@davidsonccc.edu
INVESTIGATIVE ASSOCIATES & CONSULTANTS, INC.
(In association with Davidson Community College)
AUTHORIZATION FOR RELEASE OF INFORMATION & RECORDS

I, ______________________________________________, understand that in consideration of my application for a clinical rotation at a healthcare facility associated with Davidson Community College, an investigation will be conducted. I authorize Investigative Associates & Consultants, Inc. to conduct such an investigation, which may include, but not be limited to, the gathering of information regarding verification of prior employment, education, references, consumer credit history, driving history, and any criminal history which may be in the files of any state, federal, or local criminal justice agencies. I understand that I have the right to request, in writing, a complete and accurate disclosure of the nature and scope of this investigation. I authorize Investigative Associates & Consultants to transmit a copy of my background investigation to other entities such as hospitals or clinical sites where I may participate in additional clinical rotations. I understand that the information requested below regarding sex, race, date of birth, and maiden name is for the sole purpose of gathering information accurately.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>(BIRTH) Middle Name</th>
<th>Social Security #</th>
<th>Mo.</th>
<th>Day</th>
<th>Yr</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Maiden, Previous Married, and all other Alias names used

<table>
<thead>
<tr>
<th>Driver’s license #</th>
<th>State</th>
<th>Sex</th>
<th>Race</th>
</tr>
</thead>
</table>

Daytime Telephone Number

Email Address

Present Address

City/State

Zip/County

How long?

List all other addresses used for the past 7 years - use additional page(s) if needed.

<table>
<thead>
<tr>
<th>Previous Address</th>
<th>City/State</th>
<th>Zip/County</th>
<th>How long?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Address</td>
<td>City/State</td>
<td>Zip/County</td>
<td>How long?</td>
</tr>
<tr>
<td>Previous Address</td>
<td>City/State</td>
<td>Zip/County</td>
<td>How long?</td>
</tr>
</tbody>
</table>

If you have lived in the following states within the last seven years; Alabama, Arkansas, District of Columbia, Georgia, Idaho, Iowa, Massachusetts, Minnesota, New Hampshire, New Jersey, South Dakota, or Virginia, you will be asked to complete an additional form at the time of your interview.

If you have lived in Delaware, Nevada, Ohio, South Dakota, West Virginia or Wyoming, you will need to obtain the appropriate fingerprint card(s) at the time of your interview.

A telephone facsimile or photographic copy of this authorization shall be as valid as the original.

____________________________________________________________
PROGRAM - COURSE

Investigative Associates & Consultants, Inc.
3796 Vest Mill Road
Winston-Salem, NC 27103
Telephone: (336) 768-7040 Telefax: (336) 768-2728 E-mail: info@iacinvestigations.com
Do not send any documentation to Admissions. It is strongly recommended to submit all of these materials well in advance of any deadlines so that any omissions or incomplete records may be corrected.

Checklist of Required Documentation

PLEASE COMPLETE THESE FORMS CAREFULLY & COMPLETELY, KEEP A COPY, AND SUBMIT DOCUMENTS DIRECTLY TO WENDY BUNDY. 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.

- ___ **Family & Personal Health History form** - to be completed by student AND if under 18 years of age, also signed by parent/guardian. **PLEASE NOTE: A PHYSICAL EXAMINATION IS NOT REQUIRED.**

- **Immunization Record** (documentation for immunizations can be on provided on the second page of the health history form or on another form signed or stamped by a clinical agency). All documentation must include an authorized signature or clinic stamp.
  
  - ____ **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 5, 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 and return to Wendy Bundy.
- _____ Statement of Understanding Regarding Seasonal Influenza Vaccination (page 8)
    An annual seasonal flu immunization is required every fall. Please complete the statement of understanding form and return to Wendy Bundy.

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.
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:

____________________________________________________________________________________
____________________________________________________________________________________

Have you 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: ______________________

Clinic/Office stamp:
DAVIDSON COUNTY COMMUNITY COLLEGE

STATEMENT OF POLICY REGARDING CLINICAL TRAINING
IN THE FOLLOWING PROGRAMS

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

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.
DAVIDSON COUNTY COMMUNITY COLLEGE

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
☐ Healthcare Interpreting  ☐ Health Information Technology
☐ Histotechnology  ☐ 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: ___________________