ACC – CEWD HealthCare Programs

NAME:	DATE OF BIRTH:
PLEASE READ ENTIRE APPLICATION PACKET & WORK THROUGH EACH STEP	

Certain CEWD healthcare programs have clinical hours or externships required to complete. Because of this clinical component requirement, the following pages of this packet and the coversheet must be completed.

Alvin Community College cannot make an exception to any of these requirements.

Should you have any questions about the requirements or in completing the application, you may call 281.756.3787, email HEALTH@ALVINCOLLEGE.EDU or correspondence (mailed to the campus). Any mail must be labeled **CEWD** to prevent your mail from being directed to another ACC Department. A complete mailing address is: 3110 Mustang Rd., Alvin, Texas 77511

Applications are accepted year-round for all CEWD HealthCare Programs. This completed Application Packet will be reviewed individually.

****You will need to meet with the Program Coordinator or Director of CEWD HealthCare Programs when you drop off this completed application. (See below - Step 3) Call 281.756.3806 to schedule an appointment.****

			√
STEP 1	**Please indicate CEWD program of choice:**		**√**
	Certified Nursing Assistant (CNA)		
	Clinical Medical Assistant (CMA)		
	Dental Assistant (DA)*		
	Massage Therapy (MT)*		
	Phlebotomy (PLB)		
	Veterinary Assistant (V)		
STEP 2	**Cover Sheet-1**	Indicate in STEP 1 program of choice – Insert Name & DOB - **Page 1**	
	ACC – CEWD HealthCare Application-2	Application attached to this packet with ER contact. - **Page 2**	
	Healthcare Vaccinations-3	View list Provided in Packet – **Page 3** *Be prepared to show original document*	
	Physical/Health Status Report-4	Use CEWD Healthcare Form Provided in this packet.- **Page 4**	
	Social Security Card & Driver's License	Copy of originals, *Be prepared to show original document*	
	High School Grad OR GED **Not required for CNA.**	Copy of Diploma/Certificate with application. *Be prepared to show original document* DATE COMPLETED HS or GED:_________________	
	CPR	MUST BE CERTIFIED BEFORE START OF CLINICAL COURSE	
STEP 3	**Meet with Program Coordinator** **OR** **Director CEWD HealthCare Programs**	MUST HAVE ADMISSIONS APPLICATION/CE REGISTRATION FORM SIGNED PRIOR TO REGISTRATION IN H103	
STEP 4	**Background Check**	Must be completed through ACC Campus Police ***Applicants who have been convicted of a felony must contact the appropriate credentialing agency to determine eligibility.***	
STEP 5	**REGISTER FOR CLASSES H103!**	PAYMENT IS DUE AT TIME OF REGISTRATION.= SEE STEP 3	

PLEASE READ ENTIRE APPLICATION PACKET & WORK THROUGH EACH STEP

CEWD Healthcare Programs

APPLICATION FOR PROGRAM ADMISSION

SOC SEC# ______-_____-_________ ACC Student ID_______________ Date of Birth ______________
Leave blank if you do not have one.) *mm/ dd/ yyyy*

NAME____________________________, _________________________________, _______________________________________
Last *First* *Middle Initial and or Maiden Name*

ADDRESS ____
Number & Street City County State Zip Code

PHONE (________) ______________________________ ALTERNATE PHONE (________) ____________________________

EMAIL ADDRESS (REQUIRED)____

EMERGENCY CONTACT ____
(Name) (Relationship) (Phone #)

If you answer YES to any of the following, please contact the Program coordinator or Director of CEWD Healthcare.

Y N Have you ever been convicted of a drug related felony or a felony involving moral turpitude?
Y N Have you ever been chronically or habitually intoxicated or addicted to intoxicants, drugs, or controlled substances?
Y N Have you ever been the subject of a pending prosecution for an offense that is a felony under the law of Texas?
Y N Have you ever received deferred adjudication or been arrested or convicted of a crime?
Y N Have you ever been convicted of, entered a plea of nolo contendere or guilty to, or received deferred adjudication for any criminal offense or offense involving prostitution or other sexual offense?

Are you physically capable of performing CPR? Y N Are you current with suggested vaccinations? Y N
Can you provide documentation of vaccinations? Y N If, no, please explain _______________________________

I understand that my potential for employment is greatly enhanced if I am able to read speak and write English at a level to allow accurate patient data collection, patient instruction and daily interaction with the public and other dental professionals. Suggested prerequisite courses, passing scores on an appropriate assessment examination OR department approval will be required for admission to the program. Any tests and/or additional classes will be assessed at the application review. Any additional expense to administer such tests and/or classes will be the responsibility of the student. ____________(Please initial)

It is the student's responsibility to:

Return the application packet to the Program Coordinator or the Director of CEWD Healthcare,the personnel of the CE/Workforce Development Office located in H103, or by mail. Include a copy of the checklist completed, and all required documentation enclosed for review and approval by the chosen plans due date. **Please do not fax or email due to privacy and the security of application.**

3110 MUSTANG ROAD, ALVIN, TX 77511-4898 **Phone: 281-756-3806**

I HEREBY UNDERSTAND THE APPLICATION PROCESS AND STATE THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____
(Signature) (Date)

STUDENTS WITH DISABILITIES

This college adheres to all applicable federal, state, and local laws, regulations, and guidelines with respect to providing reasonable accommodations as required affording equal educational opportunity. ACC provides reasonable accommodations for qualified individuals who are students with disabilities. It is the student's responsibility to contact the Counseling Center in a timely manner to arrange for appropriate accommodations. Once the disability is identified, please notify your Instructor for additional modifications.

FOR OFFICE USE ONLY **REVIEWED BY:** ____ **DATE** ________________

☐ Completed ☐ Not completed Student Given Background Check/ Packet~ Date___________________ Student to attend Orientation on _____________________

IMMUNIZATION RECORD **ACC CEWD Healthcare Programs**

Student Name: ____ Date of Birth _________________________

Checklist and General Information regarding Immunizations:

All applicants must provide a copy of written documentation from a physician or public health authority for:

____ **Varicella** (Chicken pox) - Proof of either (a) a physician-documented history of the disease, or (b) documentation of two varicella immunizations, or (c) a serum titer confirming immunity. ** ***Note***: The varicella injection series is a four-week process. If first dose of varicella was received prior to thirteen years of age only one dose necessary. Proof of date of birth must be included.

____ **Hepatitis B** - Proof of either: (a) a complete three-injection series of hepatitis B vaccinations, or (b) a serum titer confirming immunity. ** ***Note***: The hepatitis B injection series is a 4-6 month process. There must be a minimum of four weeks between the 1st and 2nd immunization, minimum of eight weeks between the 2nd and 3rd immunization, and a minimum of sixteen weeks between the 1st and 3rd immunization.

____ **Measles** - Proof of either: (a) two doses of measles vaccine on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: Students born before Jan. 1, 1957 are exempt from the measles requirement. There must be at least four weeks between the first and second measles vaccination.

____ **Mumps** - Proof of either: (a) one dose of mumps vaccination on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: Students born before Jan. 1, 1957 are exempt from the mumps requirement.

____ **Rubella** - Proof of either: (a) one dose of mumps vaccination on or after first birthday, or (b) a physician-documented history of disease, or (c) a serum titer confirming immunity. ** ***Note***: All students are required to show proof of rubella.

*****Combined MMR vaccine is vaccine of choice if recipients are likely to be susceptible. *****

____ **Tetanus** (TdaP) - Proof of tetanus vaccination within the last 10 years; at time of application

____ **Tuberculosis** (TB) - Proof of TB test (PPd skin test or chest x-ray) with a negative reading.

Tuberculosis Screening. Skin test **OR** Chest x-ray (if skin test is positive).
Must be within 12 months prior to start of clinical courses.

TB Test Date:	Date Read:
Chest x-ray date:	Results:

____ **Bacterial Meningitis Vaccination** (MCV4) – Per state legislation – SB 1107, beginning Jan. 1, 2012, certain college students under the age of 22 years must receive this vaccination. **Including CE courses of 360 hours or more Dental Assistant & Massage Therapy**.

____ **Flu** (Influenza) - Proof of 1 dose of influenza vaccine annually for **Phlebotomy Students**

*****Important:*** Documentation of immunizations are required at the time of application and/or completed by the start of all clinical class enrollments and clinical visits to affiliate sites. Program applications may not be accepted without completed immunization documentation. Vaccines administered on or after September 1, 1991 must include the mm/dd/yy each vaccine was given.

The Texas Dept. of Health requires immunizations for students enrolled in health related courses.
Visit http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html for suggested immunizations.

Date (mm/dd/yr)	Vaccine	Validation Signature/Stamp
	Bacterial Meningitis or Booster	
	MMR (measles, mumps, rubella)	
	TdaP (Tetanus/Diphtheria)	
	Hepatitis B (3 doses)	
	Varicella (Chickenpox) /Date of Disease	Must complete statement below

I, ____ hereby state that all information provided above is true and
(Print Student/Patient Name)
accurate to the best of my knowledge.

____
(Signature of Student) (Date)

Medical History & Physical Exam Form   ACC CEWD Healthcare Programs

Student/Patient Name:____ **Date of Birth:**____________________________

NOTE: While confidentiality of this information will be maintained, full health information disclosure is necessary for the student's protection as well as that of others.

To be completed by Student PRIOR TO PHYSICAL EXAM VISIT

1. Medical History:

Please answer the following for any condition which you have received medical treatment within the **past five years**:

Y	N	Rheumatic fever	Y	N	Menstrual disorders	Y	N	Joint disease
Y	N	Back injuries	Y	N	Epilepsy	Y	N	Cardiovascular disease
Y	N	Hay fever	Y	N	Diabetes	Y	N	Eye/Vision Impairment
Y	N	Frequent colds	Y	N	Tuberculosis	Y	N	Thyroid disease
Y	N	Anemia	Y	N	Asthma	Y	N	Ulcer/colitis
Y	N	Hypertension	Y	N	Frequent headache	Y	N	Other (please describe)

Date of last Eye Exam**?**   /   /   Date of last Dental Exam?   /   /

Y N **Currently pregnant?** *If yes, expected DUE DATE is _________________*
You must provide attending OB/GYN or Physician's release on below ***Functions***

Y N **Physical limitations?**

If you have physical limitations, please review the Essential Functions of the Healthcare Program you plan to enroll in.

Chronic illnesses? (describe)

If you have a chronic illness, you must have ***your physician of record*** *review the requirements below and clear your examination*

Current medications? (list)

If you take medications for a chronic illness, you must have ***your physician of record*** *clear your examination.*

To be completed by Primary Care Provider

Have you seen the student/patient prior to today's examination?	**Y**	**N**	_________**Initial**
Are you the student's/patient's Primary Care Provider?	**Y**	**N**	_________**Initial**
Was the above information completed by the student/patient prior to your examination?	**Y**	**N**	_________**Initial**

2. Physical Examination:

The Primary Care Provider is requested to make a complete physical examination of the student and note any deviations from normal.

Height	Weight	Pulse	B/P	Vision Corrective Lens? Y N R / L /

SYSTEM	NORMAL	SYSTEM	NORMAL	FUNCTIONS	NORMAL
Heart		Ears		Gross motor skills (reach, stoop, move)	
Eyes		Abdomen		Fine motor skills (squeeze w/ fingers)	
Skin		Reflexes		Physical endurance (push/pull/lift 50+ pounds)	
Neck		Musculoskeletal		Physical endurance (stand for long periods)	
Lungs		Balance		Mobility (respond rapidly, move independently)	

Describe any deviations from normal or abnormal findings:

I examined ____ and found him/her to be in __________________________ health.
(Student /Patient Name)   (poor, fair, average, good, excellent)

Provider's Name (Please Print)	**Provider's Signature (Please Sign)**
Office Address (Street)	Telephone
City State Zip	Date

ALVIN COMMUNITY COLLEGE CONTINUING EDUCATION WORKFORCE DEVELOPMENT
Phone: 281-756-3806 Fax: 281-756-3952 Email: health@alvincollege.edu