

ACC – CEWD Healthcare Programs

Alvin Community College - CEWD
3110 Mustang Rd.
Alvin, Texas 77511

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

Certain CEWD Healthcare Programs require completion of clinical hours or externships. 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 this application or the requirements,
call CEWD at 281.756.3787 or email HEALTH@ALVINCOLLEGE.EDU

Applications accepted year-round for all CEWD Healthcare Programs.

The Program Coordinator, CEWD Administrative Personnel or Director of CEWD Healthcare Programs will review this completed Application Packet individually. (See STEP 3)

Packet Checklist

STEP 1	Indicate CEWD Healthcare Program(s) of choice:		✓
	Certified Nursing Assistant (CNA)		
	Clinical Medical Assistant (CMA)		
	Dental Assistant (DA)		
	Phlebotomy (PLB)		
Veterinary Assistant (V)			
STEP 2	Cover Sheet	Indicate in STEP 1 program(s) of choice – Insert Name & DOB - Page 1	
	ACC – CEWD Healthcare Application	Complete the application - Page 2	
	Healthcare Vaccinations	Review the list provided in packet for your program needs – Page 3 Attach a copy of the originals; <i>Be prepared to show original document</i>	
	Physical/Health Status Report	Use the Medical History & Physical Exam Form, in this packet- Page 4	
	Social Security Card & Driver’s License	Attach a copy of originals; <i>Be prepared to show original document</i>	
	High School Graduate OR GED®	Copy of Diploma/Certificate with application <i>Be prepared to show original document</i> DATE COMPLETED HS or GED®: _____	
	Not required for CNA or Vet. Asst.		
CPR	MUST BE CERTIFIED BEFORE START OF CLINICAL COURSE		
STEP 3	Meet with Program Coordinator, CEWD Administrative Personnel OR Director CEWD Healthcare Programs	PLAN TO SHOW ORIGINAL DOCUMENTS FROM STEP 2 (ABOVE) TO REGISTRATION IN H103	
STEP 4	Background Check and HB 1508	May complete these forms at time of registration. <i>Applicants who have been convicted of a felony must contact the appropriate credentialing agency to determine eligibility.</i>	
STEP 5	REGISTER FOR CEWD HEALTHCARE CLASSES IN H103	PAYMENT IS DUE AT TIME OF REGISTRATION. SEE STEP 3	

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Alvin Community College is an equal opportunity institution and does not discriminate against anyone on the basis of race, religion, color, sex, pregnancy, gender equity, sexual orientation, parental status, national origin, age, disability, family medical history or genetic information, political affiliation, military service or veteran’s status.

CEWD Healthcare Programs

APPLICATION FOR PROGRAM ADMISSION

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** Are you currently abusing or have you ever been chronically or habitually addicted to controlled substances (excluding tobacco and caffeine)?
- Y N** Have you ever been charged with or convicted (including a nolo contendere plea or guilty plea) of a felony (or criminal offense) in any state or in federal court (other than minor traffic violations) whether or not sentence was imposed or suspended?
- Y N** Have you ever had any application for any professional license/registration?
- Y N** Was your license refused, denied or voluntarily surrendered by any licensing authority?

Are you physically capable of performing CPR? **Y N** Are you current with required vaccinations (Page 3)? **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 healthcare 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, the Director of CEWD Healthcare Programs or the Personnel of the CE/Workforce Development Office located in H103. Complete all pages of the packet including all required documentation for review and to proceed in the chosen program(s) due date.

Registration of the chosen program should occur one (1) week prior to the first day of class.

I HEREBY UNDERSTAND THE APPLICATION PROCESS AND STATE THAT ALL INFORMATION PROVIDED 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 Office of Disability in a timely manner to arrange for appropriate accommodations. Once the disability is identified, the ADA counselor will notify your Instructor for additional modifications.

FOR OFFICE USE ONLY

REVIEWED BY: _____ DATE _____

Completed Not completed Student Given Background Check/ Packet~ _____ Student has reviewed HB 1508 _____

Items missing: _____

Student Name: _____ Date of Birth _____

Important: As of July 28, 2016 per the amended Texas Administrative Code, Rule 97.64 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 will 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.

If you don't have your immunization records, look in these places:

- The doctor's office or public health clinic where you got your shots
- Your family records, such as a baby book
- Your high school
- ImmTrac, the Texas Immunization Registry
- A college or university you've attended, if they had immunization requirements
Institutions where immunization records might be found usually have rules for how long they are kept, so very old records may no longer be available.

Blood work proving immunization (titer test) may be used as replacement in documentation of immunity.

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 **Documentation of Date:** _____

_____ **Tuberculosis** (TB) - Proof of TB test (PPd skin test or chest x-ray) with a negative reading. Must be within 12 months prior to start of clinical courses.

Dental Assistant and Phlebotomy Students

_____ **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. **Needed only for the CE program of Dental Assistant which are 360 hours or more.**

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

Medical History & Physical Exam Form

ACC CEWD Healthcare Programs

Student/Patient Name: _____ Date of Birth: _____

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 headaches	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 with the Program Coordinator or the Director of CEWD Healthcare the Essential Functions of the 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:

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

Please review the below chart of CEWD Health Care program information. Per the requirements of House Bill 1508, make note of limitations of licensing or employment due to offenses of your background check. This new statute requires that any educational institution offering a program that prepares a student for an occupational license be notified of the below four items in order to comply with the statute:

1. The potential ineligibility of an individual who has been convicted of an offense for issuance of an occupational license upon completion of the program;
2. Current guidelines by any licensing authority that may issue an occupational license to an individual who completes a program;
3. State/local guidelines used by a licensing authority to determine eligibility for a license;
4. The student’s right to request a criminal history evaluation letter.

Program Name	Exam Costs/Licensing Information	Website
Certified Nursing Assistant	\$85.50 - Department of Aging & Disability Services/Texas Health and Human Services	https://hhs.texas.gov/doing-business-hhs/licensing-credentialing-regulation
Clinical Medical Assistant	\$90 - National Center for Competency Testing (NCCT) - Online registration testing within 6 months of graduation or \$135 after 6 months of graduation. \$20 Test sitting fee at ACC	https://www.ncctinc.com/
Non-Certified Radiological Technician	\$60 Online with Texas Medical Board, \$39.50 Fingerprinting - Identigo	http://www.tmb.state.tx.us/page/non-certified-radiological-technicians https://uenroll.identigo.com/workflows/11G62J
Phlebotomy Technician	\$135 ASCP Route 2 exam after 100 hours/100 documented sticks	https://www.ascp.org/content/board-of-certification/get-credentialed
Dental Assistant	\$70 (1064 class fee) online with UT Dental School, San Antonio \$36 TX State Board of Dental Examiners Online Application with \$15 Passport Photo \$5 National Practitioner Data Bank (NPDB) Self-Query Report & \$39 IdentoGO Fingerprinting = \$95 for Licensing	https://www.tsbde.texas.gov/CriminalHistoryEvaluationAssistants.html
Veterinary Assistant	\$135 TVMA CVA level1 taken at ACC after independent 300 hours.	https://tvma.azurewebsites.net/Certifications/CVA
Medical Office Billing & Coding	Student may independently pursue once they work 2 years in the field	Recommended: https://www.aapc.com/certification/cpb/
Activity Director	\$ 100 NCCAP (Nat'l) or \$ 125 CTAC (Texas)	https://nccap.memberclicks.net/activity-professional-certification https://ctractexas.org/certification/levels-of-certification/activity-director-texas-certified-fact-sheet/
Medication Aide for Nurse Assistant	\$25 - Department of Aging & Disability Services/Texas Health and Human Services	https://hhs.texas.gov/doing-business-hhs/licensing-credentialing-regulation

Due to merging of many departments within the State of Texas, please take the time to review the website for your licensing authority **prior to enrollment** into a Continuing Education Health Care program. Students who have been convicted of a felony must contact the appropriate credentialing agency to determine eligibility. Many agencies have a criminal history evaluation. If there is no criminal evaluation and you have had a prior conviction, it may be difficult to find employment in the health care industry.

I have read this information sheet and understand it is my responsibility to ensure no issues regarding my criminal history limit me from gaining the respective licensing.

Student Signature Date

Reviewed by Date