STUDENT INFORMATION PACKET 2021

The following is a step by step guide to enter into the clinical portion of the Registered Respiratory Care Program.

PLEASE *READ CAREFULLY* AND FOLLOW ALL INSTRUCTIONS

Step 1 Complete and return the Acceptance Notification Form **ONLY, as soon as possible** to retain your position in the class. You may e-mail your response.

(Bring ALL other forms to the first day of class)

Step 2 **Physical Form** (Cream Sheet) - – Make your appointment date as soon as possible. ***Dates are important*** –
Check the boxes when completed! Be SURE your Health Care Provider has documented in ***all*** the spaces.

- ☐ Complete Physical form on both sides (cream sheet)
  - side 1 completed by student
  - side 2 completed by Health Care Provider
- ☐ 2-Step TB Skin Test with placement dates, reading dates, and results. First test is placed, read within 48-72 hours. Student returns 1-3 weeks later for second placement. Second test is placed, read 48-72 hours later. After the initial 2-step TB skin test, students will complete an annual 1-step test. Chest x-ray required if TB skin test is positive.
- ☐ Tetanus (TDAP) with date (must have been received within previous 10 years)
- ☐ (2)) MMRs with date or rubella AND rubeola AND mumps titers that indicate immunity
- ☐ (3) Hepatitis B vaccine dates or Hepatitis B titer that indicates immunity
- ☐ (2)Varicella vaccine dates or Varicella titer that indicates immunity
- ☐ Current season flu shot (student will submit flu shot annually as seasonal flu shot becomes available)

If titers are drawn to show immunity, ***titer report listing results and immunity reference ranges*** *must be submitted with the physical form. Contraindications for MMR, Hep B, or Varicella must be documented by Healthcare Provider.*

*****STUDENT MUST TURN IN ORIGINAL CREAM COLORED PHYSICAL FORM FROM THE HEALTH PROGRAMS OFFICE. NO COPIES OR UNOFFICIAL FORMS WILL BE ACCEPTED. PHYSICALS WILL BE CURRENT FOR 2 CALENDAR YEARS FROM THE DATE OF ADMINISTRATION BY THE HEALTH CARE PROVIDER AS LONG AS THE STUDENT MAINTAINS CONTINUOUS ENROLLMENT.**

Step 3 Photos - One (1) photos (candid shots from home is fine) with name on back. You will not get these back. *(Bring the first day of class)*

Step 4 Health Insurance Card: Submit a copy of your current health insurance card. Due to clinical facility requirements, you must notify the health programs office should any health insurance coverage change during the program.

Step 5 Please complete and/or sign: STUDENT HANDBOOK available on line to read (*bring all signed forms to first day of class*). All consent forms are valid for 2 calendar years from date signed unless student readmitted.

Immunization Verification	Professional Behavior Agreement
Health Insurance Consent	HIPAA
Consent Forms	Student/Patient Consent
Drug/Alcohol Abuse Policy	Student Profile
Release of Student Information	Student Handbook Signature (online)

Step 6 Criminal Background Check: A Truescreen criminal background check is required for participation in all clinical experiences. Students will be required to submit a clear background check to requesting clinical facilities. The cost will be approximately $58. Instructions for ordering your background check will be provided at orientation.

Step 7 CPR – Submit copy of front/back of CPR Card. Completion card must be American Heart Association, Health Care Provider BLS. No other types of CPR will be accepted. Bring *the first day of class.*

Step 8 Liability Insurance: Liability insurance is required for participation in all clinical experiences. Students will be required to submit the cover sheet on the *first day of class*. The cost will be approximately $38. Instructions for ordering your Liability insurance will be provided at orientation. *It is policy that all students must carry this insurance.*

Step 9 **TAP** (Tennessee Assistance Program) $5 Fee is due the first day of class (money order made payable to TAP).

Step 10 MAKE A COPY OF ALL DOCUMENTATION BEFORE SUBMITTING! Professional development implies that YOU maintain your personal records of the above. Documentation submitted will not be returned for any reason.

√ Put a CHECK by your steps when you have completed them all.

To assist us in allowing others into the program, please notify us if your plans have changed. Call 423-798-7964 or email sara.smith@ws.edu

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
IMMUNIZATION VERIFICATION

Due to your potential risk for exposure to blood or other potentially infectious materials, you may be at risk of acquiring Hepatitis B Virus (HBV) infection, measles, mumps, rubella, or varicella (chicken pox). Health Programs students must provide documentation of complete vaccinations or titers from their healthcare provider. For varicella, students with disease history may have their healthcare provider document date of disease.

A student may be exempt from this requirement under one of the following circumstances:

1) The vaccine is contraindicated for the individual based on guidelines established by manufacturer or Center for Disease Control.
2) Physician judgment based on the individual's medical condition and history – (risk of harm outweighs benefit).
3) Religious belief or practice – (individual must provide written statement affirmed under penalty of perjury).

Indicate one choice of action to each vaccination listed below.

I. Hepatitis B (HBV):

_____Documentation of three (3) shot dates.
_____Titer showing immunity status to Hepatitis B.*
_____Documentation from my health care provider stating reason for contraindication.**
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.**

II. MMR (Measles, Mumps, Rubella):

_____Documentation of two (2) shot dates.
_____Titers showing immunity status to rubella, rubeola and mumps.*
_____Documentation from my health care provider stating reason for contraindication.**
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.**

III. Varicella (Chicken Pox):

_____Documentation of two (2) shot dates.
_____Titer showing immunity status to varicella.*
_____History of disease with date documented by health care provider.
_____Documentation from my health care provider stating reason for contraindication.**
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.**

I have read and understand this information. I have made a selection for each vaccination.

___________________________________ ___________________________________
STUDENT SIGNATURE **DATE**

*****Students who provide titers with laboratory values inconsistent with immunity are encouraged to get the vaccinations.*

*****Student must submit documentation for medical or religious contraindications.*

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
HEALTH INSURANCE CONSENT FORM

I,_________________________am enrolled in Health Programs at Walters State Community College (WSCC).

Place initials beside each section.

_____I. Clinical Affiliates may require students carry health insurance. I must adhere to the requirements of the Clinical Affiliates I am assigned to as a Walters State Clinical Student.

_____II. I must be able to show proof of personal health insurance coverage should a Clinical Affiliate request to see it.

_____III. I am responsible for all costs incurred related to health insurance, health problems, or accidents that may occur while functioning in the role of a student.

_____IV. If I cannot meet the requirements of Clinical Affiliates to participate in the clinical portion of the course(s) in which I am currently enrolled, I will not be able to continue in the course(s).

_____V. I understand that should my insurance status change for any reason, I will notify the Health Programs Division immediately.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in WSCC Health Programs. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

This in no way negates or limits policies and procedures in program specific material.

_________________________________ _________________________

Student Signature **Date**

____

Student Name (Print)

WALTERS STATE COMMUNITY COLLEGE
DEPARTMENT OF RESPIRATORY CARE
CONSENT FORM

I. I hereby give permission for the WSCC Department of Respiratory Care to release information regarding my malpractice insurance policy and CPR certification to the clinical agency where I am assigned.

STUDENT NAME ____________________________

DATE ____________________________

II. I have received a copy of the Student Handbook for the WSCC Respiratory Care Program. I agree by my signature to abide by the contents within. Failure to abide with the requirements stated herein will result in appropriate action by the Respiratory Care faculty.

STUDENT NAME ____________________________

DATE ____________________________

III. Permission to Photocopy
I hereby give my permission for photocopying of my written work. I understand that this material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

STUDENT NAME ____________________________

DATE ____________________________

IV. I hereby give permission for the WSCC Department of Respiratory Care to release my name, address and phone number for professional and recruiting purposes, i.e. employment.

STUDENT NAME ____________________________

DATE ____________________________

V. I hereby give permission for the WSCC Department of Respiratory Care to post my grade by an assigned confidential (secret) number.

STUDENT NAME ____________________________

DATE ____________________________

VI. I have read the Standard Precautions Procedure. I agree by my signature to abide by the contents within.

STUDENT NAME ____________________________

DATE ____________________________

VII. I authorize educational instructors to answer all questions asked concerning my ability, character, reputation and previous employment/educational record. I release all such persons from any liability or damages on account of having furnished such information.

STUDENT NAME ______________________________

DATE ______________________________

VIII. In accordance with the Clinical affiliation Agreement between Walters State Community College and the Contracted Clinical Facilities, Section II, Number 9, I (print your name) __________________ give permission for a copy of my current Health History and Physical which was submitted to the Respiratory Care Program as an entrance requirement and/or for continued clinical practice to be released to the Office of Respiratory Care Administration at the contracted facility(s) where I am assigned. I understand that this information will be released only by request of the clinical facility(s).

STUDENT NAME ______________________________

DATE ______________________________

IX. I understand that WSCC strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

STUDENT NAME______________________________

DATE ______________________________

X. I hereby give my permission for the Walters State Community College Respiratory Care Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the Respiratory Care Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation and development, and publicity.

STUDENT NAME______________________________

DATE ______________________________

These images will be retained by Walters State Respiratory Care Program.

Failure of the student to sign the consent forms may not permit the review of the applications for admission to Respiratory Care or retention in the program.

Signature will indicate acceptance/understanding/compliance of policies throughout enrollment in the WSCC Respiratory Care Program.

Consent to Drug/Alcohol Testing
Statement of Acknowledgment and Understanding
Release of Liability

I,___________________________am enrolled in the Allied Health and/or Respiratory Care program at Walters State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Walters State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff; and property. Accordingly, I understand that prior to participation in the clinical experience; I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Walters State Community College.

If I am a licensed health profession, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test result is positive. Full reinstatement of my license would be required for unrestricted return to the Walters State Community College Allied Health and/or Respiratory Care Program.

My signature below indicates that:

1.) I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.
2.) I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the Director of the Allied Health and/or Respiratory Care Program, and others deemed to have a need to know.
3.) I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Walters State Community College, and the Drug-Free Campus/Workplace Policy of Walters State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
4.) I hereby release and agree to hold harmless Walters State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicated that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Allied Health and/or Respiratory Care Program at Walters State Community College.

____________________________________ __________________
Student's Signature **Date**

WALTERS STATE COMMUNITY COLLEGE AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION AND ACKNOWLEDGEMENT

I,__________________________hereby authorize Walters State Community College, ("Institution") including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of my background check and credential check(s) as these terms are generically used by background check agencies, hospitals, clinics and similar medical treatment facilities, to disclose the same to such facilities and the appropriate institutional administrators and faculty providing clinical instruction at such facilities, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic, or similar medical treatment facility may exclude me from clinical placement on the basis of a background check. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation. I release Institution and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check.

Any hospital, clinic or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic or similar medical treatment facility to which I am assigned, I will provide the results of my background check to be used for audit purposes only.

______________________________________ **Student Signature**

______________________________________ **Print Name**

______________________________________ **Date**

AGREEMENT FOR STUDENTS IN THE HEALTH PROGRAMS AT WSCC REGARDING STUDENT CONDUCT

The WSCC Health Program student agrees to conduct himself or herself in a professional, honorable, and ethical manner.

I. Professional Behaviors
   - A. Actively participates and accepts responsibility for learning
   - B. Effectively communicates
   - C. Demonstrates dependability
   - D. Demonstrates appropriate adaptability
   - E. Appropriately utilizes resources
   - F. Maintains acceptable level of personal appearance

II. Honorable and Ethical Behaviors
   - A. Demonstrates accountability for all actions
   - B. Demonstrates respect in all situations
   - C. Demonstrates ethical behavior in all situations

By accepting admission to the health programs as WSCC you are voluntarily agreeing to abide by the Student Conduct Agreement.

This in no way negates or limits policies and procedures in program specific material.

Signature of student________________________________Date _________

WALTERS STATE COMMUNITY COLLEGE
RESPIRATORY CARE PROGRAM

Student Confidentiality/Non-Disclosure Acknowledgement (HIPPA)

Student____

As a student in the Respiratory Care Program, I understand that I will be working with medical records and confidential information for patients at various healthcare facilities.

I understand that healthcare facilities remind their employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue.

The healthcare facility/facilities that I may be assigned to have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at any healthcare facility that is an Affiliate of Walters State Community College, I may come into possession of confidential patient information.

Medical records are confidential, legal, personal documents. The contents of individual patient's medical records are to be kept strictly confidential. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at any time during or after my assignment with the Affiliate healthcare facility disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other that as necessary in the course of my assignment. When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care.

Respiratory Care students must also treat as confidential all information relating to the personal, financial, and business affairs of the healthcare facility and its employees.

I pledge not to discuss the contents of any patient's medical record or any confidential information which comes to my knowledge except when such discussion is relative to the learning experience. I further agree to abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines in effect at the individual healthcare facility to which I am assigned. I understand that a violation of confidentiality in any of the above-described areas may be grounds for dismissal from the Respiratory Care Program. I also understand that I may be in violation of the regulations of the Health Insurance Portability and Accountability Act of 1996 as effective April 14, 2003.

____

Student's Signature **Date**

Walters State Community College
Health Programs Division
Respiratory Care Program

I understand that as part of the laboratory/clinical experience in Respiratory Care Program courses, I will be required to participate as the role of "patient".

As the "patient", I will be required to act as a human subject by: allowing instructors/fellow students to demonstrate/practice examination/assessment on me; demonstrate/practice therapeutic skills with me; apply various therapeutic modalities on me; and instruct me in various therapeutic exercises. I understand that I will be given equal opportunity to practice the same techniques on fellow students as they participate in the role of "patient".

In conjunction with my above role as "patient", I hereby certify that it is my responsibility to disclose any medical or physical condition that would prohibit me from participating in the above role of patient, including any or all indications, precautions, or contraindications to any modality, exercise, or activity. I understand that I will be informed of these indications, precautions, and contraindications during the curriculum prior to assuming the role of "patient" for any modality, exercise, or activity. If I am diagnosed with any medical or physical condition or become pregnant during the course of the curriculum, I will notify my instructor(s) immediately that I should not participate in a particular activity. I understand that all medical information will be kept confidential.

Student Name ______________________________________ Date _______________
(Print)

Student's Signature ______________________________________ Date _______________

Respiratory Care Program

Class of 2023

Student Information Profile

Name ____
Last First Middle/Maiden

Social Security Number____________-____________-____________

Mailing Address ____
Street/Number City Zip

Phone Number ______________________________ ________________________
Home Cell

E-mail Address: ____

Phone Number and Name of a Person We Can Contact in Case of an Emergency

________________________ __________________ __________________
Name Phone Number Relationship

Name You Wish To Be Called During Class/Clinical: _______________________

Acceptance Notification
Form Class of 2023

Instructions: You have been selected as either an accepted or an alternate candidate for the Registered Respiratory Care Program beginning fall 2020 term. To retain your position in the selection process, you must complete and return this form to the Respiratory Care Program. If you do not reply, you may lose your position in the class.
You may also reply to the following e-mail address: Sara.Smith@ws.edu

Yes, I will enter the Respiratory Care Program this fall.

No, I will not enter the Respiratory Care Program this fall.

Name: ____

MAIL TO:

Sara Smith, MHA, RRT
Respiratory Care Program
Walters State Community
College 221 N. College Street
Greeneville, TN 37745

OR e-mail
Sara.Smith@ws.edu

Return as soon as possible!