MILWAUKEE AREA Technical College

Surgical Technology

Petition Requirements & Forms

All MATC Health Science students are required to complete criminal background check, drug testing and health requirements* **AFTER** being selected** through the petition process for their program. After being selected to continue the petition process, you will need to complete additional steps before being fully admitted to your program.

Once you have been selected to move forward in the petition process, you must complete a mandatory orientation where instructions for completing these requirements will be provided. The forms below will be used to complete the program requirements.

***** The cost of the criminal background check, drug testing, health examination and immunizations are your responsibility. You may be able to obtain health care services at your local Health Department or you may call IMPACT@ 1-866-211-3380 for a list of clinics in your area.

******Please note that being selected through the petition process, does not guarantee full admission to your program.

DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE!

If you have any questions about uploading forms, call the **MATC Petition Office at 414-297-6088** or contact CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com

HEALTH REQUIREMENTS (Forms attached for your use)

- ☐ **(1) Physical Examination Form**
- ☐ **(2) Measles, Mumps and Rubella (MMR) Vaccination Form**
- ☐ **(3) Varicella (Chicken Pox) Vaccination Form**
- ☐ **(4) Tuberculosis Test Form**
- ☐ **(5) Tetanus Vaccination Form**
- ☐ **(6) Hepatitis B Vaccination Form**
- ☐ **(7) Handbook Acknowledgement Form**
- ☐ **(8) Liability Release Form**
- ☐ **(9) CPR Certification Form**
- ☐ **(10) Essential Functions Signature Form (upload this page only)**
- ☐ **(11) Ocular History and Medical Laser Surveillance (Eye Exam) Form**
- ☐ **(12) Influenza (Flu) Vaccination Form**
- ☐ **(13) Drug Test Verification Form (upload this page only)**
- ☐ **(14) Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment Form**

OTHER

☐ **Criminal Background Check (Refer to castlebranch.com)**
Note: *You must disclose* ***everything*** *that is part of your record on the self-disclosure form (BID), regardless of the outcome. All MATC clinical affiliates reserve the right to deny student placement at their facilities. If placement is denied, you will not be able to complete or graduate from your program.*

☐ **Drug Testing (Refer to castlebranch.com)**
Note: *You must upload the drug test verification form in your health requirements profile.*

MILWAUKEE AREA Technical College

Student Information

(Print Name and Address)

NAME: _____ **BIRTHDATE:** _____/_____/_____ **ADDRESS:**

_____ **CITY/STATE** _____ **ZIP CODE** _____ **Program Name:**

_____ **Telephone #:** _____

Cell Phone #: _____ **E-Mail Address**: _____

Student ID #: _____

IMPORTANT:
I give my permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

_____
Student Signature

MILWAUKEE AREA Technical College

Physical Examination
(1)

VERIFICATION OF STUDENTS GOOD HEALTH
(Only Physician, Physician Assistant, or Nurse Practitioner, to Complete the Following:

I have examined _____ and certify that she/he is in good physical and mental health.
Student's Name

On letterhead stationery, please list any physical limitations or other disabilities which would limit this individual's capacity to perform the essential functions of this profession. (See attached)

_____ _____
Physicians, Physician Assistant or Nurse Practitioner SIGNATURE & Medical Title *Date*

Print Professional's Name:_____OfficeTelephone #_____

Address:_____City:_____State:_____Zip:_____

A full exam is on file at: _____

***I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

***Student Name:** _____**Signature**:_____ ***ID #:** _____

MILWAUKEE AREA Technical College

Measles, Mumps and Rubella (MMR) Vaccination (2)

Proof of at least two MMR's at least 30 days apart or blood test evidence of rubella and measles immunity. A copy of the titer lab results must be attached if a blood test is performed.

1) MMR **Date: _____** **Authorized Signature & Medical Title: _____**

2) MMR **Date: _____** **Authorized Signature & Medical Title: _____**

OR

Rubella Titer _____ Date: _____ **Authorized Signature & Medical Title: _____**

AND

Rubeola Titer _____ Date: _____ **Authorized Signature & Medical Title: _____**

***I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

***Student Name:** _____**Signature:**_____ **ID #:** _____

MILWAUKEE AREA Technical College

Varicella (Chicken Pox) Vaccination
(3)

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have positive blood titer test or documentation of 2 shot vaccinations at least 30 days apart. A copy of the titer lab results must be attached if a blood test is performed.

RESULTS

Has this patient had?

Chicken Pox _____ _____ _____ _____
Yes *No* *Date* *Authorized Signature & Medical Title*

OR

Varicella Vaccine #1 _____ _____
Date *Authorized Signature & Medical Title*

30 Days later #2 _____ _____
Date *Authorized Signature & Medical Title*

OR

Varicella Titer _____ _____ _____
Date *Results* *Authorized Signature & Medical Title*

***I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

Student Name: _____ ***Signature:*** _____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Tuberculosis Test
(4)

TWO STEP MANTOUX TUBERCULIN SKIN TEST:

Documentation of a Two Step test must be submitted. Skin tests are good for 1 year. If the 2-step is more than a year old, attach documentation of the past 2-step dates, along with a current annual update.

PROCEDURE:
Step 1:
A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered under the skin on the forearm.
A health care professional must read the results within 48-72 hours. If negative perform step 2. If positive, must follow- up with a chest x-ray.
Step 2
Repeat the test within 7 to 30 days after the application of the first test using the same strength of PPD.
A health professional must read the results within 48-72 hours.
If positive, must follow-up with a chest x-ray.

QUANTIFERON – TB GOLD TEST:

The TB Gold blood draw may be performed in place of skin tests. TB gold blood draws are good for one year and a copy of the lab report must be attached to the health packet.

REPORTING RESULTS (2 Step or Chest X-Ray or TB Gold)

1. Step 1 Results

_____ _____ _____ _____ *Date Administered*
Date Read *Results* *Authorized Signature & Medical Title*

2. Step 2 Results

_____ _____ _____ _____ *Date Administered*
Date Read *Results* *Authorized Signature & Medical Title*

Chest X-Ray (if required)

_____ _____ _____ _____ *Date Administered*
Date Read *Results* *Authorized Signature & Medical Title*

TB Gold Titer (if required)

_____ _____ _____ _____ *Collection Date*
Date Read *Results* *Authorized Signature & Medical Title*

Annual Update

_____ _____ _____ _____ *Date Administered*
Date Read *Results* *Authorized Signature & Medical Title*

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: _____***Signature***_____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Tetanus Vaccination
(5)

PROOF OF TETANUS VACCINATION: (Within the last 10 years)

_____ _____

Date *Authorized Signature & Medical Title*

I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others

Student Name: _____ ***Signature:*** _____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Hepatitis B Vaccination
(6)

Please read thoroughly and check the appropriate box.

☐ As a student, I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been advised to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can pursue the vaccination series. I hereby release Milwaukee Area Technical College, its Board Members, and personnel, and any clinical facility at which I train from any liability for any consequences to me or any claims arising out of or related to my decision to be or not to be vaccinated. I hereby agree to indemnify all of the above persons and organizations for any and all claims, including the attorneys' fees and costs, which may be brought against any one of them by anyone claiming to have been injured as a result of any injury which may occur as a result of my decision.

OR

☐ I do not wish to decline the Hepatitis B vaccine. I am currently in the process/or have completed the series. Understand that full immunity requires three doses of vaccine over a nine-month period.

_____
Signature of Student *Student ID#* *Date*

_____
Print Name

IF HBV given:

1st Dose Date: _____ _____
Authorized Medical Signature

2nd Dose Date: _____ _____
Authorized Medical Signature

3rd Dose Date: _____ _____
Authorized Medical Signature

I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: _____***Signature:***_____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Handbook Acknowledgement
(7)

School of Health Sciences
Student Handbook Signature Page

I acknowledge that I am responsible for the contents of the current School of Health Sciences Student Handbook located on the MATC website at:

http://www.matc.edu/student/Admissions/upload/Health_Sciences_handbook.pdf

I further agree to abide by the terms and conditions found in the contents of the current School of Health Sciences Student Handbook.

Student Signature: _____

Student Name: *(Please print)* _____

Student MATC ID Number: _____

Signature Date: _____

***I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

Student Name: _____***Signature***_____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Liability Release
(8)

ACCEPTANCE OF RISKS AND RESPONSIBILITYAGREEMENT AND RELEASE OF LIABILITY

This Acceptance of Risks and Responsibility Agreement and Release of Liability ("Agreement and Release") is executed by: _____ (please print student first and last name ("Participant") and is issued to
Participant is participating in a COLLEGE affiliated Program/Course/Practicum/ Training/Activity ("Activity"). This Activity is more fully described in each of the MATC School of Health Sciences program pages, which have been provided to Participant.

Participant understands that there are certain dangers, hazards, and risks inherent in the Activity. These include, but are not limited to, contact with sharp, contaminated medical instruments, contagious diseases, infectious blood and/or body fluids, electrical instruments, electronic devices or other risks associated with patient care/non-patient care and the particular site.. In certain circumstances, these dangers can include damage/destruction to property, severe bodily injury, and even death.

Participant agrees to exercise reasonable care at all times with respect to Participant's own safety and with respect to the safety of others. Participant agrees to abide by all rules, policies and procedures of the COLLEGE that are set forth in the Code of Conduct found in the COLLEGE's Student Handbook, as well as any additional rules, policies and procedures of the location of the Activity. Participant has no health-related issues that would preclude or restrict participation in the Activity.

Accordingly, Participant, on behalf of him/herself, the Participant's spouse (if applicable), the Participant's heirs, assigns, related individuals and related entities, does hereby WAIVE, RELEASE, AND DISCHARGE the COLLEGE, including its Board of Trustees/Directors, administrators, officers, employees, teachers, agents and insurers, from any and all claims, causes of action, suits, damages, or liabilities sounding in negligence, which the Participant has, shall have, or may have in the future against the COLLEGE arising out of, based on, related to, or connected with, the Participant's enrollment and participation in the Activity. *This release of liability does not, however, apply to any intentional or reckless acts or conduct by the COLLEGE.*

This Agreement and Release shall be governed by the laws of the State of Wisconsin, which shall be the forum for any lawsuits filed under, or incident to, this Agreement and Release.

By signing this document, Participant acknowledges that s/he is fully informed of the contents of this Agreement and Release, and represents that s/he understands it. Participant is not relying on any oral or written representations, statements or inducements, apart from those made in this Agreement and Release.

Participant is at least eighteen (18) years of age, and is competent to sign this document. If Participant is a minor under the age of eighteen (18), the parent and/or guardian acknowledges they are competent to sign this document on behalf of the Participant.

By signing this Agreement and Release, you give up substantial legal rights. Read and understand this entire document before you sign it.

_____ _____
Participant Date

_____ _____
Parent/Legal Guardian *(Signature required if Participant is under age 18.)* Date

MILWAUKEE AREA Technical College

CPR Certification
(9)

CPR Verification:

American Heart Association 2 year Healthcare Provider level only.

Sign your CPR card and upload a copy of the FRONT and BACK of the card to castlebranch.com.

MILWAUKEE AREA Technical College

Essential Functions Signature Form
(10)
(Upload this page only)

ADA AND ESSENTIAL FUNCTIONS

The Americans with Disabilities Act (ADA) of 1990 (42 USC & 12101. et seq.) and the ADA Amendment Act of 2008, and Section 504 of the Rehabilitation Act of 1973 (29 USC & 794) prohibits discrimination of persons because of her or his disability. In keeping with these laws, Milwaukee Area Technical College makes every effort to insure a quality education for students. To aid in student success, it is important to inform students of the essential functions demanded by a particular occupation. The purpose of this document is to ensure students acknowledge that they have been provided information on the essential functions required for their chosen program. To meet the Essential Functions, information on accommodations is available upon request of the applicant. Please visit the MATC Student Accommodation Services Department.

INSTRUCTIONS

- ☐ Click on **YOUR** program link below.
- ☐ Read the essential functions required for success in your program.
- ☐ If you have read and understood the essential functions for your program, sign and date this form below.

DENTAL PROGRAMS	ALLIED HEALTH PROGRAMS	NURSING PROGRAMS
Dental Assistant	Anesthesia Technology	Nursing Assistant
Dental Assistant Bilingual	Cardiovascular Technology	Nursing Assistant Bilingual
Dental Hygiene	Clinical Lab Technician	Practical Nursing
Dental Technician	Dietetic Technician	LPN-RN Educational Progression
	Funeral Service	Registered Nursing
	Health Information Technology	
	Health Unit Coordinator	
	Healthcare Services Management	
	Medical Assistant	
	Medical Coding Specialist	
	Medical Interpreter Technician	
	Occupational Therapy Assistant	
	Optician-Vision Care	
	Pharmacy Technician	
	Phlebotomy	
	Physical Therapy Assistant	
	Radiography	
	Renal Dialysis	
	Respiratory Therapist	
	Surgical Technologist	

COMPLETE, INITIAL AND SIGN

Student Name: _____ **Student ID#:** _____

My program is: _____

_____**(Initial)** I have read and understand the Essential Functions criteria specific to a student in my program indicated above.
_____**(Initial)** I am able to meet the Essential Functions as presented with or without accommodation.
_____**(Initial)** I was provided with information concerning accommodations or special service if needed.

Note: The program you indicated above must be the program to which you have applied. Completion of this form verifies that you have read and understand the essential functions required. If you have applied to more than one program, this form must be completed for each of those programs.

_____ _____
Signature *Date*

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: _____***Signature:***_____ ***ID #:*** _____

MILWAUKEE AREA Technical College

Ocular History and Medical Laser Surveillance (11)

Name: _____

Program: _____ **Student ID:** _____

Have you, or someone in your family ever had any of the following:

	Your History		Family History	
• Blackouts	Yes	No	Yes	No
• Diabetes	Yes	No	Yes	No
• Glaucoma	Yes	No	Yes	No
• Headaches	Yes	No	Yes	No
• Heart Problems	Yes	No	Yes	No
• High Blood Pressure	Yes	No	Yes	No
• Previous Eye Problems	Yes	No	Yes	No
• Retinal Problems	Yes	No	Yes	No
• Cataracts	Yes	No	Yes	No
• Thyroid Problems	Yes	No	Yes	No
• Other chronic medical problems	Yes	No	Yes	No

If you answered "yes" to any of the above questions, please clarify: _____
_____

Please list all of your current medications (include birth control and vitamins): _____
_____

Please list all allergies to food, medication, or the environment: _____
_____

Have you ever worked with lasers before? **Yes** **No**

If yes, what type of laser did you work with? _____
Where did you work? _____
What position did you hold? _____

Have you ever been involved in a laser accident? **Yes** **No**
If yes, what were your injuries? _____
_____

Do you wear glasses? **Yes** **No**
Do you wear contacts? **Yes** **No**
If yes, for what purpose? _____
Date of most recent eye exam: _____

Student Signature: _____ **Date:** _____

Examine Results: _____ **Date:** _____

Examined By: _____ **Date:** _____

MILWAUKEE AREA Technical College

Ocular History and Medical Laser Surveillance (cont.)
(11)

Jaeger:
Near point Acuity
With/without Rx: _____
O.D. _____
O.S. _____
O.U. _____

Color Vision:
O.D. _____/9
O.S. _____/9

Distance Visual Acuity:
O.D. _____
O.S. _____
O.U. _____

Time:
Tonometer O.D. _____
Readings O.S. _____

Keratometer: O.D. _____/_____
Readings: O.S. _____/_____

Recommended course action:

_____
_____
_____
_____

Date: _____

MILWAUKEE AREA Technical College

Influenza (Flu) Immunization
(12)

As a patient safety initiative, the School of Health Sciences at MATC requires influenza vaccinations for all students in all health programs.

STUDENT INFORMATION:

Name: _____ Date of Birth: _____

Student ID#: _____ Program: _____

***I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.**

Student Name: _____Signature:_____ ID #: _____

For Clinic/Office Use only

⇩ ⇩

Vaccine Information:

Vaccine Administered *(Trade name):* **_____ Vaccination Date: _____**

Vaccine Lot#: _____

Facility Information:

Name of Location: _____

Street Address: _____ City: _____

State: _____ Zip/Postal Code: _____

Phone Number: _____

Name and Title of Vaccinator *(Please Print):* **_____**

Signature of Vaccinator: _____ Date: _____

MILWAUKEE AREA Technical College

Drug Test Verification Form
(13)
(Upload this page only)

Drug Test Verification:

I acknowledge that my drug test **RESULTS** were posted on my CastleBranch, Inc. profile on (date)**:** _____

Student Signature: _____

Student Name: *(Please print)* _____

Student MATC ID number: _____

Signature Date: _____

MILWAUKEE AREA Technical College

Health Insurance Portability Accountability Act (HIPAA Training)
(12)

I acknowledge that I am responsible for the contents of the current School of Health Sciences HIPAA Training located on the MATC website.

1. HIPAA-Privacy Rule for Covered Entities
2. HIPAA- Security Rule for Covered Entities

I further agree to abide by the terms and conditions found in the contents of the HIPAA training courses.

Student Signature: _____

Student Name: *(Please print)* _____

Student MATC ID Number: _____

Signature Date: _____

*****Information to access the training will be provided by the program coordinator.*****

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: _____***Signature***_____ ***ID #:*** _____

MILWAUKEE AREA Technical College

INSTRUCTIONS TO STUDENTS

PLEASE NOTE: You MUST make a copy of your completed health forms and retain it.
DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE

SUMMARY OF MATERIALS TO BE COMPLETED

Health Requirements

- ❑ (1) Physical Examination Form
- ❑ (2) Measles, Mumps and Rubella (MMR) Vaccination Form
- ❑ (3) Varicella (Chicken Pox) Vaccination Form
- ❑ (4) Tuberculosis Test Form
- ❑ (5) Tetanus Vaccination Form
- ❑ (6) Hepatitis B Vaccination Form
- ❑ (7) Handbook Acknowledgement Form
- ❑ (8) Liability Release Form
- ❑ (9) CPR Certification Form
- ❑ (10) Essential Functions Signature Form (upload this page only)
- ❑ (11) Ocular History and Medical Laser Surveillance (Eye Exam) Form
- ❑ (12) Influenza (Flu) Vaccination Form
- ❑ (13) Drug Test Verification Form (upload this page only)
- ❑ (14) Health Insurance Portability and Accountability Act (HIPAA)

Acknowledgment Form

Other

- ❑ Criminal Background Check (refer to castlebranch.com)
- ❑ Drug Testing (refer to castlebranch.com)

If you have any questions about uploading forms:

Call or email CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com

or call the MATC School of Health Sciences at 414-297-6263.