

## Respiratory Therapist 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](mailto: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) Influenza (Flu) Vaccination Form
- (12) Drug Test Verification Form (upload this page only)
- (13) Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment Form

**OTHER** **Criminal Background Check (Refer to [castlebranch.com](http://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](http://castlebranch.com))**

**Note:** You must upload the drug test verification form in your health requirements profile.



**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*



**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: \_\_\_\_\_ Office Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

A full exam is on file at: \_\_\_\_\_

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**Student Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **ID #:** \_\_\_\_\_



**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 #:** \_\_\_\_\_

**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 &amp; Medical Title

**OR****Varicella Vaccine #1**

Date

Authorized Signature &amp; Medical Title

**30 Days later****#2**

Date

Authorized Signature &amp; Medical Title

**OR****Varicella Titer**

Date

Results

Authorized Signature &amp; 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 #:** \_\_\_\_\_



**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 Read*      \_\_\_\_\_ *Results*      \_\_\_\_\_ *Authorized Signature & Medical Title*      \_\_\_\_\_ *Date Administered*

**2. Step 2 Results**

\_\_\_\_\_ *Date Read*      \_\_\_\_\_ *Results*      \_\_\_\_\_ *Authorized Signature & Medical Title*      \_\_\_\_\_ *Date Administered*

**Chest X-Ray (if required)**

\_\_\_\_\_ *Date Read*      \_\_\_\_\_ *Results*      \_\_\_\_\_ *Authorized Signature & Medical Title*      \_\_\_\_\_ *Date Administered*

**TB Gold Titer (if required)**

\_\_\_\_\_ *Date Read*      \_\_\_\_\_ *Results*      \_\_\_\_\_ *Authorized Signature & Medical Title*      \_\_\_\_\_ *Collection Date*

**Annual Update**

\_\_\_\_\_ *Date Read*      \_\_\_\_\_ *Results*      \_\_\_\_\_ *Authorized Signature & Medical Title*      \_\_\_\_\_ *Date Administered*

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**Student Name:** \_\_\_\_\_ **Signature** \_\_\_\_\_ **ID #:** \_\_\_\_\_



**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 #:** \_\_\_\_\_





**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 #:** \_\_\_\_\_



**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](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 #:** \_\_\_\_\_

**Liability Release**

**(8)**

**ACCEPTANCE OF RISKS AND RESPONSIBILITY AGREEMENT  
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

**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.****



**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
<a href="#">Dental Assistant</a>	<a href="#">Anesthesia Technology</a>	<a href="#">Nursing Assistant</a>
<a href="#">Dental Assistant Bilingual</a>	<a href="#">Cardiovascular Technology</a>	<a href="#">Nursing Assistant Bilingual</a>
<a href="#">Dental Hygiene</a>	<a href="#">Clinical Lab Technician</a>	<a href="#">Practical Nursing</a>
<a href="#">Dental Technician</a>	<a href="#">Dietetic Technician</a>	<a href="#">LPN-RN Educational Progression</a>
	<a href="#">Funeral Service</a>	<a href="#">Registered Nursing</a>
	<a href="#">Health Information Technology</a>	
	<a href="#">Health Unit Coordinator</a>	
	<a href="#">Healthcare Services Management</a>	
	<a href="#">Medical Assistant</a>	
	<a href="#">Medical Coding Specialist</a>	
	<a href="#">Medical Interpreter Technician</a>	
	<a href="#">Occupational Therapy Assistant</a>	
	<a href="#">Optician-Vision Care</a>	
	<a href="#">Pharmacy Technician</a>	
	<a href="#">Phlebotomy</a>	
	<a href="#">Physical Therapy Assistant</a>	
	<a href="#">Radiography</a>	
	<a href="#">Renal Dialysis</a>	
	<a href="#">Respiratory Therapist</a>	
	<a href="#">Surgical Technologist</a>	

**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 #: \_\_\_\_\_

**Influenza (Flu) Vaccination**  
**(11)**

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: \_\_\_\_\_



**Drug Test Verification Form**  
**(12)**  
*(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:** \_\_\_\_\_



**Health Insurance Portability Accountability Act**  
**(HIPAA Training)**  
**(13)**

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 #:** \_\_\_\_\_



## 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) Influenza (Flu) Vaccination Form
- (12) Drug Test Verification Form (upload this page only)
- (13) Health Insurance Portability and Accountability Act (HIPAA)

#### Acknowledgment Form

#### Other

- Criminal Background Check (refer to [castlebranch.com](http://castlebranch.com))
- Drug Testing (refer to [castlebranch.com](http://castlebranch.com))

### If you have any questions about uploading forms:

Call or email CastleBranch, Inc. at [888-914-7279](tel:888-914-7279) or [studentservices@castlebranch.com](mailto:studentservices@castlebranch.com)

or call the MATC School of Health Sciences at [414-297-6263](tel:414-297-6263).