MILWAUKEE AREA Technical College

Nursing Assistant - Bilingual

Program Requirements Checklist

All MATC Health Science students are required to complete criminal background check, drug testing and health requirements after being accepted through the petition process for their program. MATC School of Health Sciences has partnered with Certified Background.com to provide record tracking for all MATC Health Sciences students. The cost of all record tracking is the responsibility of the student.

Use the steps below to complete the Certified Background (CB) electronic record tracking process.

- ☐ Visit CertifiedBackground.com website: www.certifiedbackground.com
- ☐ Look for the **place order box** on the homepage.
- ☐ Enter the **package code MF43** (package code is specific to the Nursing Assistant program)
- ☐ Follow the directions to setup your CB account

* 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 1-866-211-3380 for a list of clinics in your area.

HEALTH REQUIREMENTS (Forms attached for your use)

☐ **(1) Physical Examination**

☐ **(2) Tuberculosis Test**

☐ **(3) Hepatitis B Vaccination**

☐ **(4) Essential Functions Form**

☐ **(5) Influenza (Flu) Vaccination**

OTHER

☐ **Criminal Background Check (Refer to CertifiedBackground.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 CertifiedBackground. Com)**

(doc..revised 10-2013)

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act

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

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

Tuberculosis Test
(2)

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 #:*** _____

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Hepatitis B Vaccination
(3)

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 #:*** _____

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Essential Functions Form
(4)

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 at this time.

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

Influenza (Flu) Vaccination
(5)

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:** _____

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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
- ❑ (2) Tuberculosis Test
- ❑ (3) Hepatitis B Vaccination
- ❑ (4) Essential Functions Form
- ❑ (5) Influenza (Flu) Vaccination

Other

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

If you have any questions about uploading forms:

Call or email Certified Background at 888-914-7279 or studentservices@certifiedprofile.com

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

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