

Nursing Assistant Petition Requirements & Forms

All MATC Healthcare Pathway students are required to complete criminal background check, drug testing and health requirements after being accepted through the admission or petition process for their program. MATC Healthcare Pathway has partnered with castlebranch.com to provide record tracking for all MATC Healthcare Pathway students. The cost of all record tracking is the responsibility of the student.

Use the steps below to complete the CastleBranch, Inc. (CB) electronic record tracking process.

- Visit castlebranch.com website: www.castlebranch.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.

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) Tuberculosis Test Form

(3) Hepatitis B Vaccination Form

(4) Essential Functions Signature Form (upload this page only)

(5) Influenza (Flu) Vaccination Form

(6) Drug Test Verification Form (upload this page only)

(7) Criminal Background Check (CBC) and Self-Disclosure (BID) Verification Form (upload this page only)

(8) Covid-19 Vaccination Completion - upload a copy of you Wisconsin Immunization Record (WIR) or Electronic Health Record (EHR)

(9) Health Insurance Portability and Accountability Act (HIPAA) (See instruction page and upload copy of certificate upon completion of the course.)

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.

Note: You must upload the CBC-BID verification form in your health requirements profile after your CBC/BID has been completed.

Drug Testing (Refer to castlebranch.com)

Note: You must upload the drug test verification form in your health requirements profile after you have completed the drug test.

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: _____

****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
(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 Read	Results	Authorized Signature & Medical Title	Date Administered
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2. Step 2 Results

Date Read	Results	Authorized Signature & Medical Title	Date Administered
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Chest X-Ray (if required)

Date Read	Results	Authorized Signature & Medical Title	Date Administered
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TB Gold Titer (if required)

Date Read	Results	Authorized Signature & Medical Title	Date Administered
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Annual Update

Date Read	Results	Authorized Signature & Medical Title	Date Administered
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Student Name: _____ **Signature** _____ **ID #:** _____

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. I 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 #:** _____

Essential Functions Signature Form
(4)
(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 - Echocardiography	Practical Nursing
Dental Hygiene	Cardiovascular Technology – Invasive	Practical Nursing LPN-RN Educational Progression
	Central Service Technician	Registered Nursing
	EKG Technician	
	Health Information Technology	
	Healthcare Services Management	
	Health Unit Coordinator	
	Medical Assistant	
	Medical Coding Specialist	
	Medical Interpreter	
	Medical Laboratory Technician	
	Nutrition and Dietetic Technician	
	Occupational Therapy Assistant	
	Pharmacy Technician	
	Phlebotomy	
	Physical Therapist Assistant	
	Radiography	
	Renal Dialysis Technician	
	Respiratory Therapist	
	Surgical Technology	

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
(5)

As a patient safety initiative, the Healthcare Pathway 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

(6)

(Upload this page only)

Drug Test Verification:

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

Note: You must upload the drug test verification form in your health requirements profile after ordering/paying/completion of the drug test itself. This form prompts CastleBranch to enter the next due date for the drug test requirement.

Student Signature: _____

Student Name: *(Please print)* _____

Student MATC ID number: _____

Signature Date: _____

Criminal Background Check (CBC) & Self-Disclosure (BID)
Verification Form

(7)

(Upload this page only)

Criminal Background Check (CBC) & Self-Disclosure (BID) Verification Form:

Date of last Criminal Background Check (CBC): _____

Date of last Self-Disclosure (BID): _____

Note: You complete and upload this CBC-BID verification form in your health requirements profile **after** ordering/purchasing and completion of the CBC/BID itself. This form prompts CastleBranch to enter the next due date for the CBC/BID requirement.

Student Signature: _____

Student Name: *(Please print)* _____

Student MATC ID number: _____

Signature Date: _____

Criminal Background Check (CBC) & Self-Disclosure (BID) must be renewed every 2 years.

Covid-19 Vaccination Completion

(8)

Covid-19 Vaccination Completion Process:

Upload a copy of your Wisconsin Immunization Record (WIR) or Electronic Health Record (EHR) to your CastleBranch profile

Health Insurance Portability Accountability Act
(HIPAA Training)
(9)

Student is to complete HIPAA Training provided by the North American Learning Institute by following the process below.

HIPAA Training website is <https://nlearning.org/hipaa/MATC> provided by the North American Learning Institute

- Create an Account
- Training cost is \$15
- One hour of minimal training for course. Must preview all pages, cannot skip to post test and will time out if page is left open and no activity recorded. You can stop and start course. Extra Authentication for log in.
- Must score at least 70% or greater for successful completion on Post Test. You can retake Post Test to pass.
- Course can be taken on Desktop, Laptop, Tablet or Phone
- 24/7 Support provided by the North American Learning Institute for Login or technical issues via Text, Phone or Email.
- Customer Service Phone - (407) 906-6254 • Customer Service Email - Help@nlearning.org • [Privacy Policy](#)

Upload Successful Course Completion Certificate to CastleBranch Profile



By completing this training, I acknowledge that I agree to abide by the terms and conditions found in the contents of the HIPAA training course.

INSTRUCTIONS TO STUDENTS

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

SUMMARY OF MATERIALS TO BE COMPLETED

Health Requirements

- 1.) Physical Examination Form
- 2.) Tuberculosis Test Form
- 3.) Hepatitis B Vaccination Form
- 4.) Essential Functions Form (upload this page only)
- 5.) Influenza (Flu) Vaccination Form
- 6.) Drug Test Verification Form (upload this page only)
- 7.) CBC/BID Verification Form (upload this page only)
- 8.) Covid-19 Vaccination Completion
- 9.) Health Insurance Portability and Accountability Act (HIPAA) (upload copy of Course Completion Certificate)

Other

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

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

or call the MATC Healthcare Pathway at [414-297-6263](tel:414-297-6263) or email at healthpathway@matc.edu