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)
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

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 #: ___________________________
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

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

2. Step 2 Results

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

Chest X-Ray (if required)

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

TB Gold Titer (if required)

<table>
<thead>
<tr>
<th>Collection Date</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

Annual Update

<table>
<thead>
<tr>
<th>Date Administered</th>
<th>Date Read</th>
<th>Results</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**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 #: ______________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act
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 #: ___________________________
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 assure 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.

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

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 #: ____________________________

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

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

(Revised 10/2013)