

MILWAUKEE AREA TECHNICAL COLLEGE

HEALTH SERVICES MANAGEMENT HEALTH REQUIREMENTS CHECKLIST

All MATC Health Science students are required to complete and upload health requirements prior to petitioning for courses which contain a clinical component. MATC School of Health Sciences has partnered with CertifiedBackground.com to provide health record tracking for all MATC Health Sciences students. The cost of the health record tracking (\$35) is the responsibility of the student.

Use the steps below to complete the CertifiedBackground (CB) electronic health record tracking process.

1. Visit CertifiedBackground.com website: www.certifiedbackground.com
2. Click on Student
3. Enter the **package code MF98im** (package code is specific to the Health Services Management program)
4. Follow the directions to setup your CB account

* The cost of the 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.

* If a student is accepted into core technical courses via petitioning, he or she will receive instructions for completing a mandatory drug test. The cost for the drug test is an additional \$34 per a test.

TO DO:

- Acknowledgment of Essential Functions-Functional Abilities Form**
- Health Certification Requirements**
 - 1) **Certification of student's good health by a physician, physicians assistant or nurse practitioner.**
 - 2) **Immunizations**
 - a) MMR immunizations shots **1 and 2** **OR**
 - b) Rubella **AND** Rubeola titer (Lab results must be attached)
AND
 - c) Chicken pox - Proof of having had chicken pox or chicken pox immunization per authorized medical signatures **OR** Varicella titer (Lab results must be attached)
 - 3) **TB skin test, Step 1 and Step 2**
(2 negative TB skin tests within 30 days of each other)
 - a) Chest x-ray, only if TB skin test was positive
 - b) Quantiferon TB Gold blood test option
 - 4) **Tetanus Shot**
 - 5) **Hepatitis B Release Form** - Signed and verifying Hepatitis B status
 - 6) **Health Sciences Handbook Acknowledgment Form**
 - 7) **Clinical/Field Placement Liability Release Form**

MILWAUKEE AREA TECHNICAL COLLEGE
School of Health Sciences
Essential Functions
for the
Healthcare Services Management Program

The Americans with Disabilities Act (ADA) of 1990 (42 U.S.C & 12101. *et seq.*), the ADA Amendment Act of 2008, and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C & 794) prohibits discrimination of persons because of her or his disability. In keeping with these laws, Colleges of the Wisconsin Technical College System make every effort to ensure a quality education for students. The purpose of this document is to ensure that students acknowledge that they have been provided information on the essential functions abilities required of a student in the Healthcare Services Management Program.

ESSENTIAL FUNCTIONS

	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
SPEECH							
Speak English with Clarity				X	X	X	
Communicate in English with Clarity				X	X	X	
HEARING							
Conversation				X	X	X	
Telephone				X	X	X	
Communication Devices				X	X	X	
Machine Alarms Outside of Visual Field		X				X	
Blood Pressure Alarms			X		X		X
Manual Blood Pressures			X		X		X
SIGHT							
Natural or Corrected Without Assistance				X		X	
Depth Perception				X		X	
Color Vision				X		X	
Fine print on written forms/electronic devices				X		X	
Darkened Room		X					X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
MOBILITY using <u>each</u> extremity (right <u>and</u> left) as applicable							
Lift, Push or Pull 50 lbs.			X		X	X	
Shoulder				X	X	X	
Arm				X	X	X	
Neck				X	X	X	
Standing				X	X	X	
Move about Facility				X	X	X	
Bending			X		X	X	
Crawling		X					X
Kneeling		X					X
Twisting Body				X	X	X	
Running		X					X
Walking				X	X	X	
Climbing							
Stairs			X		X	X	
Other	X						X
REACHING using <u>each</u> extremity (right <u>and</u> left) as applicable							
Overhead				X	X	X	
In Front of Body				X	X	X	
Down				X	X	X	
GRASPING							
Overhead				X	X	X	
In Front of Body				X	X	X	
Down				X	X	X	
SITTING				X	X	X	
SMELLING		X					X
TASTING	X						X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
FINE MOTOR CONTROL (working with small objects and using each hand (right <u>and</u> left).							
Hands				X	X	X	
Fingers/Tactile Sense (the ability to feel when touching)				X	X	X	
Wrist				X	X	X	
COORDINATION							
Eye/Hand with both hands/arms				X	X	X	
Eye/Hand/Foot with both hands/arms/feet				X	X	X	
ALLERGIES/ SENSITIVITIES							
Tolerance to Latex			X		X		X
Other allergies to chemicals, etc.			X		X		X
COGNITIVE/MENTAL FACTORS							
REASONING							
Deal with abstract and concrete variables, define problems, collect data, establish facts, and draw valid conclusions				X	X	X	
Interpret instructions furnished in oral, written, diagrammatic, or schedule form				X	X	X	
Deal with problems varying from standard to critical situations				X	X	X	
Carry out detailed/ involved written or oral instructions				X	X	X	
Carry out multiple step instructions				X	X	X	
MATHEMATICS							

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Complex skills - Business math, algebra, geometry or statistics			X		X	X	
Simple skills - add, subtract, multiply and divide whole numbers and fractions, calculate time and simple measurements				X	X	X	
READING							
Complex skills - Comprehend medical records, manuals, journals, instructions in use and maintenance of equipment, safety rules and procedures and drawings				X	X	X	
Simple skills - Comprehend simple instructions or notations from a log book				X	X	X	
WRITING							
Complex skills - Prepare medical documentation, report summaries using prescribed format and conforming to all rules of punctuation, spelling, grammar, diction and style				X	X	X	
Simple skills - English sentences containing subject, verb and object; names and addresses, complete job application or notations in a log book				X	X	X	
PERCEPTION							
Spatial - ability to comprehend forms in space and understand relationships of plane and solid objects; frequently described as the ability to "visualize" objects of two or three dimensions, or to think visually of geometric			X		X	X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
forms							
Form - ability to perceive pertinent detail in objects or in pictorial or graphic material; to make visual comparisons and discriminations and see slight differences in shapes and shadings of figures and widths and lengths of line			X		X	X	
CLERICAL							
Ability to perceive pertinent detail in verbal or tabular material; to observe differences in copy, to proof-read words and numbers, and to avoid perceptual errors in arithmetic computation.				X		X	
DATA							
Synthesizing				X	X	X	
Coordinating				X	X	X	
Analyzing				X	X	X	
Compiling				X	X	X	
Computing				X	X	X	
Copying				X	X	X	
Comparing				X	X	X	
PERSONAL TRAITS							
Ability to respond to requests person to person and over the telephone in a timely manner				X	X	X	
Ability to comprehend and follow instructions				X	X	X	
Ability to perform simple and repetitive tasks				X	X	X	
Ability to maintain a work pace appropriate to a given work load				X	X	X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Ability to relate to other people beyond giving and receiving instructions				X	X	X	
Ability to influence people				X	X	X	
Ability to perform complex or varied tasks				X	X	X	
Ability to make generalizations, evaluations or decisions without immediate supervisor				X	X	X	
Ability to accept and carry out responsibility for direction, control and planning				X	X	X	
ENVIRONMENTAL FACTORS							
Works indoors				X	X	X	
Works outdoors		X					X
Exposure to extreme hot or cold temp		X					X
Working at unprotected heights	X						X
Being around moving medical equipment/ machinery			X		X	X	
Exposure to marked changes in temperature/humidity		X					X
Exposure to dust, fumes, smoke, gases, odors, mists or other irritating particles (aerosol spray from equipment)			X		X		X
Exposure to toxic or caustic chemicals		X					X
Exposure to excessive noises		X					X
Exposure to radiation or electrical energy		X					X
Exposure to solvents, grease, or		X					X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
oils							
Exposure to slippery or uneven walking surfaces		X					X
Working in confined spaces			X		X	X	
Using computer monitor				X	X	X	
Working with explosives	X						X
Exposure to vibration	X						X
Exposure to flames or burning items	X						X
Works alone			X		X	X	
Works around others				X		X	
Works with others				X		X	
Exposure to Blood and Other Potentially Infectious Material (OPIM)			X			X	
SAFETY EQUIPMENT (REQUIRED TO WEAR)							
Safety glasses		X					X
Face mask/face shield		X					X
Ear plugs							X
Hard hat							X
Protective clothing		X					X
Protective gloves		X					X

MILWAUKEE AREA TECHNICAL COLLEGE
School of Health Sciences
Essential Functions
for the
Healthcare Services Management Program

This form will be received with the Healthcare Services Management information and application packet. It is to be completed and uploaded to www.certifiedbackground.com after completing your profile.

_____ I have read and understand the *Essential Functions Criteria* specific to a
(initials/date) student in the **Healthcare Services Management** Program.

_____ I am able to meet the *Essential Functions Criteria* as presented with or
(initials/date) without accommodation.

_____ I was provided with information concerning accommodations or special
(initials/date) services if needed at this time.

Name of Student (Please print)

Signature of Student

Date

The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

www.certifiedbackground.com

HEALTH CERTIFICATION

(Print Name and Address)

NAME: _____ BIRTHDATE: _____ / _____ / _____
ADDRESS: _____ City/State _____ Zip Code _____
PROGRAM NAME: _____ TELEPHONE #: _____
Cell Phone #: _____ E-Mail Address: _____
STUDENT ID # or SS# : _____

ONLY PHYSICIAN, PHYSICIAN ASSISTANT, 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 stationary, 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 _____
Street _____ City _____ State _____ Zip Code _____

A full exam is on file at _____

IMMUNIZATIONS

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 _____
Results _____ Date _____ Authorized Signature & Medical Title _____

AND

Rubeola Titer _____
Results _____ Date _____ Authorized Signature & Medical Title _____

(continue to next page)

- The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have a 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

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:

- 1). A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered under the skin on the forearm.
- 2). 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

- 1). Repeat the test within 7 to 30 days after the application of the first test using the same strength of PPD.
- 2). 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

1. STEP 1 RESULTS

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

2. STEP 2 RESULTS

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

3. ANNUAL UPDATE

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

4. CHEST X-RAY (if required)

_____	_____	_____	_____
Date Administered	Date Read	Results	Authorized Signature and Medical Title

5. TB Gold Titer

_____	_____	_____	_____
Collection Date	Date Read	Results	Authorized Signature and Medical Title

The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

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

Date

Authorized Signature and Medical Title

PLEASE NOTE: You **MUST** make a copy of your completed health form and retain it. You may need to provide it to a clinical agency.

IMPORTANT

DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE.

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

Signature of Student _____

INSTRUCTIONS TO STUDENTS

- Did your doctor or authorized medical person sign every authorized signature, dates and results of tests?
- Is your physical exam completed and all necessary information on the form complete?
i.e. (signatures, print name, address, telephone #, lab results, etc.)
- Do we have your home phone # on the space provided?
- Do you have a copy?

If you have questions about uploading forms please contact Certified Background at 888-666-7788 or email them to studentservices@certifiedprofile.com

If you have specific health related questions please email Joe Tuttle at tuttlejm@matc.edu or call 414-297-7871

Health Records and Petition Office Reception Desk

414-297-6482
between the hours of
8am. – 4pm
Monday - Friday

(Revised 10/14/11 JMT)

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

MILWAUKEE AREA TECHNICAL COLLEGE
Health Sciences Division

INFORMATION ABOUT HEPATITIS B VACCINES

THIS GENERAL INFORMATION IS PROVIDED AS A COURTESY AND MATC MAKES NO REPRESENTATION AS TO ITS ACCURACY. YOU SHOULD CONSULT YOUR PHYSICIAN FOR ALL MEDICAL INFORMATION REGARDING THE MATTERS GENERALLY DESCRIBED HERE.

The Disease and the Risks

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely, but approximately 2-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Immunization against Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

Risk of Exposure

Medical and paramedical personnel are at increased risk of contracting hepatitis depending upon their degree of exposure to the blood or body fluids (e.g. saliva, feces, sweat, vaginal secretions, respiratory secretions and other body secretions) of patient infected with Hepatitis B (known or unknown). Hepatitis B is spread by direct contact of broken skin or mucous membranes with the blood or body fluids of a person who has Hepatitis B or is a carrier of the disease. Routine or frequent handling of blood or contaminated tissue products, therefore, constitutes significant risk because of the ease of transmission of the disease and the fact that many people with Hepatitis B have no symptoms and do not know they have the disease.

The first line of defense against Hepatitis B is the Hepatitis B vaccine. Immunization with the Hepatitis B vaccine is the most effective method of preventing HBV infection.

The Vaccine

The Hepatitis B vaccine (Engerix B, Recombivax HB) is produced using recombinant DNA technology. The vaccine works by stimulating the immune system to produce antibodies to the virus.

The vaccine is given intramuscularly in the deltoid in three doses. The second dose one month after the first, and the third dose six- twelve months after the second. After vaccination, more than 90% of healthy adults develop protective antibodies. The cost is about \$150.00 for the series. Only minor adverse reactions have been reported with vaccination, including transient fever and soreness at the injection site, rash, nausea joint pain and mild fatigue have also been reported. The vaccine is not contraindicated in pregnancy.

Reference

- a. Ganza, a., Torshner, L. (1997) Hepatitis Update. RN, 60 (12), 39-44.
- b. Hepatitis B Virus Vaccine Safety: Report of an Interagency Group: MMWR 31(34): 465
September 3, 1982.
- c. Hollinger, F. Blaine: Hepatitis B Vaccines-To Switch or Not to Switch. JAMA 257 (19): 2634-2636, May 15, 1987.
- d. Inactivated Hepatitis B Virus Vaccine: Annual of Internal Medicine 97:379-83, 1982.
- e. Jilg, W., et.a.: Clinical Evaluation of a Recombinant Hepatitis B Vaccine. The Lancet: 1174-1175, November 24, 1984.
- f. Krugman, Saul: The Newly Licensed Hepatitis B Vaccine. JAMA 247 (14): 2012-15, April 1992.
- g. Leads from the MMWR: Recommendations of the Immunization Practices Advisory Committee Update on Hepatitis B Prevention. JAMA 258(4): 437-449, July 24/31, 1987.
- h. Lewis, S., Heitkemper, M., Dirkson, S., (2000). Medical Surgical Nursing. 1193-1198. Mosby.
- i. Medical College of Wisconsin, Student Health Services.

Student Name: _____

Name of Program: _____

**MILWAUKEE AREA TECHNICAL COLLEGE
Health Sciences Division**

RELEASE FORM: HEPATITIS B

Please read thoroughly and check the appropriate box.

- I have received and read the information regarding Hepatitis B and the vaccines that are available.
- I am declining the Hepatitis B vaccine.

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 am currently in the process/or have completed the series. I understand that full immunity requires three doses of vaccine over an eight to 12-month period.

Signature of Student (required)

Date

IF Hepatitis B vaccine given:

1st Dose Date: _____

Authorized Medical Signature

2nd Dose Date: _____

Authorized Medical Signature

3rd Dose Date: _____

Authorized Medical Signature

Revised: 10/14/11:JMT