

Health Occupations Division
SURGICAL TECHNOLOGY PROGRAM

The next step in the admissions process is a health examination and completion of the required forms listed below. Please return all signed forms to the MATC Health Records/Criminal Background Check/Petition Office in Room M240 at the Milwaukee Campus. 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.

Included in this packet are:

1. Health Certification Form and *Ocular History and Medical Laser Surveillance form*. Please have your physician or health care provider complete and sign the enclosed Health Certification Form.
2. Information about Hepatitis B and its vaccine, and a Hepatitis B Release Form. Please read the information and discuss it with your physician or health care provider. Complete and sign the Hepatitis Release Form.
3. Information about the essential functions for your program. Please read the information. If you have questions, discuss it with your physician or health care provider. Complete and sign the Essential Functions Form.

All forms must be completed with authorized signatures.

Return the completed Health Certification Form, the Hepatitis B Release Form and the Essential Functions Form to the MATC Health Records/Criminal Background Check/Petition Office in Room M240 at the Milwaukee Campus. If you have any questions, please contact the Health Records/Criminal Background Check/Petition Office at 414-297-7871.

Be sure to keep a copy of your completed forms.

We look forward to working with you as you complete the required documentation for your program of interest at MATC.

MATC Health Occupations Division

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division
Essential Functions
for the
Surgical Technology Program

The Americans with Disabilities Act (ADA) prohibits discrimination of persons with disabilities. In keeping with this law, MATC makes every effort to insure quality education for all students. It is our obligation to inform students of the essential functions necessary for this program and occupation.

Students requiring accommodation and/or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

The following physical, cognitive and environmental performance standards are encountered by students in this program.

	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per Day	Job Essential	
						Yes	No
GROSS MOTOR SKILLS							
Agile				X	X	X	
Moves in Confined Spaces				X	X	X	
Maintains Multiple Positions				X	X	X	
Moves About Room/Facility				X	X	X	
FINE MOTOR SKILLS							
Wrists/Hands/Fingers Dexterity				X	X	X	
Eye/Hand Coordination				X	X	X	
Eye/Hand/Foot Coordination				X	X	X	
Ambidextrous				X	X	X	
PHYSICAL ENDURANCE							
Stands most of work day				X	X	X	
Lifts, Pushes, Pulls or Supports - 50 lbs				X	X	X	
Does Repetitive Movements				X	X	X	
MOBILITY							
Shoulders				X	X	X	
Arms				X	X	X	
Neck				X	X	X	
Waist				X	X	X	
Legs/Feet				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
Bends				X	X	X	
Crawls		X					X
Kneels		X				X	
Twists Body				X	X	X	
Runs		X					X
Walks				X	X	X	
Sits				X	X	X	
Climbs			X			X	
Stairs			X			X	
Other			X			X	
Reachs							
Overhead				X	X	X	
In Front of Body				X	X	X	
Down				X	X	X	
Grasps							
Overhead				X	X	X	
In Front of Body				X	X	X	
Down				X	X	X	
HEARING							
Conversation				X	X	X	
With Background Noise				X	X	X	
Telephone Conversations				X	X	X	
Tolerates Unpleasant Sounds				X	X	X	
SPEECH							
Communicates with Clarity				X	X	X	
Speaks with Diction and Clarity				X	X	X	
VISUAL							
Visual Acuity – Natural or Corrected				X	X	X	
Visual Acuity – in Light or Dark Conditions				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
Depth Perception				X	X	X	
Peripheral Vision				X	X	X	
Color Vision				X	X	X	
Sees Differences in Instruments, Supplies, Sterilization Indicators				X	X	X	
Tolerates Unpleasant Sights			X			X	
TACTILE:							
Notes Temperature Variances				X	X	X	
Feels Differences in Instruments				X	X	X	
Tolerates Protective Apparel				X	X	X	
ENVIRONMENT:							
Works indoors				X	X	X	
Uses computer					X	X	
Works at unprotected heights	X						X
Works with moving equipment				X	X	X	
Tolerates exposure to allergens (e.g., latex, chemical substances)					X	X	
Tolerates Strong Odors		X				X	
Tolerates exposure to hot or cold air temperatures		X				X	
Exposed to dust, fumes, smoke, gases, odors, mists or other irritating particles				X	X	X	
Exposed to blood, body fluids and other potential infectious material				X	X	X	
Exposed to toxic or caustic chemicals		X				X	
Exposed to excessive noises		X				X	
Exposed to radiation or electrical energy				X	X	X	
Exposed to solvents, grease, or oils		X				X	
Exposed to slippery or uneven walking surfaces				X	X	X	
Tolerates working in confined spaces for extending periods				X	X	X	
Works with hazardous gases		X				X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per Day	Job Essential	
						Yes	No
Exposed to vibration			X			X	
Potential for flames or burning items		X				X	
MATHEMATICS							
Manages Simple Skills - Add, subtract, multiply and divide whole numbers and fractions, calculate time and simple measurements				X	X	X	
Manages Complex Skills - Business math or algebra		X				X	
READING							
Manages Simple Skills – Comprehend instructions, safety rules or other documentation. Read digital displays.				X	X	X	
Complex skills – Comprehend manuals, procedures, drawings, and instructions for use and maintenance of equipment.			X			X	
WRITING							
Manages Simple skills – Creates English sentences containing subject, verb and object; completes job application or other forms of documentation			X			X	
Manages Complex skills – Prepares business letters, reports summaries using prescribed format and conforming to all rules of punctuation, spelling, grammar, diction and style		X				X	
Interprets instructions furnished in oral, written, graphic, or schedule form				X	X	X	
Deals with problems from standard situations				X	X	X	
Carries out detailed written or oral instructions				X	X	X	
ANALYTICAL THINKING:							
Transfers Knowledge from one situation to another				X	X	X	
Processes and Interprets Information from multiple sources				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
Analyzes and interprets abstract and concrete data				X	X	X	
Evaluates outcomes				X	X	X	
Problem solves				X	X	X	
Utilizes Short-term and Long-term Memory				X	X	X	
CRITICAL THINKING							
Deals with Abstract and Concrete Variables, Defines Problems				X	X	X	
Compares, Analyzes and Evaluates Data		X				X	
Establishes Facts and Draws Valid Conclusions				X	X	X	
Makes Generalizations, Evaluations or Decisions without immediate supervision				X	X	X	
Accepts and Carries Out Responsibility for Direction, Control and Planning				X	X	X	
INTERPERSONAL SKILLS							
Comprehends and Follows Instructions				X	X	X	
Performs Simple and Repetitive tasks				X	X	X	
Performs Complex or Varied Tasks				X	X	X	
Maintains a Work Pace appropriate to a given work load				X	X	X	
Practices Good Time Management				X	X	X	
Comprehends and Exhibits Nonverbal Communication				X	X	X	
Functions and Collaborates as Part of the Surgical Team				X	X	X	
Respects/values diversity				X	X	X	
EMOTIONAL STABILITY							
Establishes/Maintains Professional Relationships				X	X	X	
Adapts to Changing Environment				X	X	X	
Successfully Handles Stress				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
Deals with the Unexpected				X	X	X	
Focuses on Tasks				X	X	X	
Copes with Own Emotions				X	X	X	
Approaches emotional situations with professionalism				X	X	X	
Performs Multiple Responsibilities Concurrently				X	X	X	
Accepts Responsibility for Own Actions				X	X	X	
Accepts Constructive Feedback				X	X	X	

If you have any questions or wish to discuss further the essential functions required of this program, please call the Health Occupations Division Office at 414-297-6263.

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division
Essential Functions
for the
Surgical Technology Program

_____ I have read and I understand the essential functions for this program.

_____ I have the ability to meet the essential functions as specified.

(Print Name of Program)

(Signed)

(Date)

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Students requiring accommodation or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

_____ I require the following accommodations to meet the essential functions as specified and I have provided supporting documentation from my health care provider to the MATC Student Accommodation Services.

(Signed)

(Date)

MILWAUKEE AREA TECHNICAL COLLEGE

HEALTH OCCUPATIONS
HEALTH REQUIREMENTS CHECKLIST

- Check off as you complete each requirement for your own reference.
- Retain the completed list as program faculty may ask to see it at the beginning of a semester.

STUDENT NAME: _____ PROGRAM _____

TO DO:

- Caregiver Background Check** (Not required for Opticianary Science, Dental Hygiene, Dental Technician, most Dental Assisting students)
- Acknowledgment of Essential Functions-Functional Abilities Form**
- Health Certification Requirements**
 - 1) **Certification of student's good health by a physician or nurse practitioner**
 - 2) **Immunizations** (Not required for CNA , Dental Technician or Optician Science)
 - a) MMR immunizations **1 and 2** OR Rubella Titer **AND**
 - b) Rubeola immunization or titer **AND**
 - c) Chicken pox - Proof of having had chicken pox or chicken pox immunization per authorized medical signature OR Varicella titer
 - 3) **TB skin test, Step 1 and Step 2** (Not required for Dental Technician or Opticianry Science) (2 negative TB skin tests within 30 days of each other)
 - a) Chest x-ray, only if TB skin test was positive
 - 4) **Tetanus Shot**
 - 5) **Hepatitis B Release Form** - Signed and verifying Hepatitis B status
 - 6) **Hepatitis B immunization dates**
 - 7) **For Renal Dialysis Students Only:** Hepatitis B Antigen / Antibody
 - 8) **For Surgical Technology Students Only:** Eye Examination

11/18/03

The applicant must: 1) Return the original complete form to MATC, Nursing Center, Room M240
2) Retain a copy to show instructor

Name _____

Program _____

MILWAUKEE AREA TECHNICAL COLLEGE
700 WEST STATE STREET
MILWAUKEE, WISCONSIN 53233

HEALTH CERTIFICATION

(Print Name and Address)

NAME: _____ BIRTHDATE: _____/_____/_____

ADDRESS: _____ City/State _____ Zip Code _____

PROGRAM NAME: _____ Semester Start _____ TELEPHONE #: _____

CELL PHONE# _____ E-MAIL ADDRESS: _____

STUDENT ID # or SS# : _____

DATE DUE: _____

This form must be completed and returned
by the above stamped date

Were you in another Health Occupations program? Yes or No
If yes, what program? _____

Date you were in program _____

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 on or after the first birthday at least 30 days apart or laboratory evidence of rubella and measles immunity.

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

-over-

The applicant must: 1) Return the original complete form to MATC, Nursing Center, Room M240
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Name _____

Program _____

CHICKEN POX

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

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: This must be administered within one year of date of program entry or, if over one year, a ONE step update must be performed. Nursing Assistant Students must have skin test within 90 days of program beginning date.

PROCEDURE:

Step 1:

- 1). A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered to all individuals who have never had a two-step skin test or to those individuals who have not had a PPD within the last two years.
- 2). A health care professional must read the results within 48-72 hours.
 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 dose 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.
 If negative, repeat (Step 1only) each year.

REPORTING RESULTS

4. Step 1 Results

 Date Administered Date Read Results Authorized Signature and Medical Title

4. Step 2 Results

 Date Administered Date Read Results Authorized Signature and Medical Title

4. ANNUAL UPDATE

 Date Administered Results Authorized Signature and Medical Title

4. CHEST X-RAY (indicated only when Tuberculin Skin Test is Positive)

 Date Administered Date Read Results Authorized Signature and Medical Title

The applicant must: 1) Return the original complete form to MATC, Nursing Center, Room M240
2) Retain a copy to show instructor

Name _____

Program _____

PROOF OF TETANUS IMMUNIZATION: (Within 10 years of program entry)

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 RETURN 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 completed?
i.e. (signature, print name, address, telephone #, test results, etc.)
- Do we have your home phone # on the space provided?
- Do you have a copy?

IF YOU HAVE ANY QUESTIONS, CALL THE NURSING CENTER

Joe Tuttle, at 414-297-7871
(Leave message if Joe Tuttle is unavailable)

OR
call

Nursing Center Reception Desk
414-297-6482
between the hours of
8:30 a.m. – 12:30 p.m.
Monday - Thursday

(s\admin\HLTHFRM2)
(Revised 2/11/03:vm)

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

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division

INFORMATION ABOUT HEPATITIS B VACCINES

THIS GENERAL INFORMATION IS PROVIDED AS A COURTESY AND MATC MAKES NO REPRESENTATION AS TO IT'S 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. Thus, 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 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 first. After vaccination, more than 90% of healthy adults develop protective antibodies. The cost is \$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.

Name _____

Program _____

**MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division**

RELEASE FORM: HEPATITIS B

1.

Please read thoroughly and check the appropriate box.

I have received and read the information regarding Hepatitis B and the vaccines that are available.

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 six-month period.

Student signature required _____ Signature of Student _____ Date _____

2.

Return this form to the Health Center as soon as possible with any information listed. Please have authorized medical signature if you have had any dosages.

IF HBV given:

1st Dose Date: _____ Authorized Medical Signature _____

2nd Dose Date: _____ Authorized Medical Signature _____

3rd Dose Date: _____ Authorized Medical Signature _____

Please Return this Form to:
MATC Health Center (Room M240)
700 West State Street
Milwaukee WI 53233

MILWAUKEE AREA TECHNICAL COLLEGE

Health Occupations

Ocular History and Medical Laser Surveillance

Name: _____

Program: _____ Student ID: _____

Have you, or someone in your family, ever had any of the following:

	Your History		Family History	
	Yes	No	Yes	No
• Blackouts	Yes	No	Yes	No
• Diabetes	Yes	No	Yes	No
• Glaucoma	Yes	No	Yes	No
• Headaches	Yes	No	Yes	No
• Heart Problems	Yes	No	Yes	No
• High Blood Pressure	Yes	No	Yes	No
• Previous Eye Problems	Yes	No	Yes	No
• Retinal Problems	Yes	No	Yes	No
• Cataracts	Yes	No	Yes	No
• Thyroid Problems	Yes	No	Yes	No
• Other chronic medical problems	Yes	No	Yes	No

If you answered "yes" to any of the above questions, please clarify: _____

Please list all of your current medications (include birth control and vitamins): _____

Please list all allergies to food, medication, or the environment: _____

Have you every worked with lasers before? Yes No

If yes, what type of laser did you work with? _____

Where did you work? _____

What position did you hold? _____

Have you ever been involved in a laser accident? Yes No

If yes, what were your injuries? _____

Do you wear glasses? Yes No

Do you wear contacts? Yes No

If yes, for what purpose? _____

Date of most recent eye exam: _____

Student Signature: _____ Date: _____

Examine Results: _____ Date: _____

Examined By: _____ Date: _____

Jaeger
Near point Acuity
With/without Rx: _____
O.D. _____
O.S. _____
O.U. _____

Color Vision:
O.D. ____/9
O.S. ____/9

Distance Visual Acuity:
O.D. _____
O.S. _____
O.U. _____

Time:
Tonometer O.D. _____
Readings O.S. _____

Keratometer: O.D. _____/
Readings O.S. _____/_____

Recommended course action:

Date: _____

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