All MATC Health Science students are required to complete criminal background check, drug testing and health requirements* AFTER being selected** through the petition process for their program. After being selected to continue the petition process, you will need to complete additional steps before being fully admitted to your program.

Once you have been selected to move forward in the petition process, you must complete a mandatory orientation where instructions for completing these requirements will be provided. The forms below will be used to complete the program requirements.

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

**Please note that being selected through the petition process, does not guarantee full admission to your program.

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) Measles, Mumps and Rubella (MMR) Vaccination Form

☐ (3) Varicella (Chicken Pox) Vaccination Form

☐ (4) Tuberculosis Test Form

☐ (5) Tetanus Vaccination Form

☐ (6) Hepatitis B Vaccination Form

☐ (7) Hepatitis B Virus (HBV) Verification – Blood Testing Form

☐ (7A) Verification of Hepatitis B Virus (HBV) Status: Blood Test Results Form

☐ (8) Handbook Acknowledgement Form

☐ (9) Liability Release Form

☐ (10) Essential Functions Signature Form (upload this page only)

☐ (11) CPR Certification Form

☐ (12) Influenza (Flu) Vaccination Form

☐ (13) Drug Test Verification Form (upload this page only)

☐ (14) Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment Form
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.

☐ Drug Testing (Refer to castlebranch.com)

Note: You must upload the drug test verification form in your health requirements profile.
(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
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 #: __________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act (rev 7/2018)
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 ___________ Date: ___________  Authorized Signature & Medical Title: _________________________

AND

Rubeola Titer ___________ Date: ___________  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 #: _________________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act  (rev 7/2018)
MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act (rev 7/2018)

**Varicella (Chicken Pox) Vaccination (3)**

**CHICKEN POX**
Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have 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?

<table>
<thead>
<tr>
<th>Chicken Pox</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
</table>

**OR**

<table>
<thead>
<tr>
<th>Varicella Vaccine #1</th>
<th>Date</th>
<th>Authorized Signature &amp; Medical Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 Days later #2</td>
<td>Date</td>
<td>Authorized Signature &amp; Medical Title</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Varicella Titer</th>
<th>Date</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 (rev 7/2018)
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

2. Step 2 Results

   Date Read Results Authorized Signature & Medical Title Date Administered

Chest X-Ray (if required)

   Date Read Results Authorized Signature & Medical Title Date Administered

TB Gold Titer (if required)

   Date Read Results Authorized Signature & Medical Title Collection Date

Annual Update

   Date Read Results Authorized Signature & Medical Title Date Administered

**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 #: ____________________
PROOF OF TETANUS VACCINATION: (Within the last 10 years)

____________________  __________________________________________
Date                                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 #: ________________
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 #: __________________________

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act  (rev 7/2018)
TO: RENAL DIALYSIS TECHNICIAN PROGRAM APPLICANTS

RE: Hepatitis B VIRUS (HBV) BLOOD TESTING

Renal Dialysis Technicians work in areas that are considered to be “high-risk” exposure areas for blood-borne pathogens (disease-producing germs). One such pathogen, the Hepatitis B Virus, is a major concern for dialysis staff members and patients because it is easily transmitted in the blood.

Current practices in dialysis require that ALL persons who perform dialysis therapy must be free of the Hepatitis B Virus, either in the active infectious state or the chronic carrier state. This practice will require periodic blood testing of the MATC dialysis technician student during the educational/clinical program year. Please be advised that any student who currently has a Hepatitis B Virus infection, or who is a carrier of the Hepatitis B Virus is NOT permitted to work with renal dialysis patients.

Laboratory studies of the student’s blood will be required for verification of the Hepatitis B Virus status. To satisfy current practices, this laboratory test must be performed prior to petitioning for entry into the program. Negative Antibody tests will have to be repeated every 6 months while in the program.

While immunization is NOT a program requirement, MATC strongly recommends that the student be immunized against the Hepatitis B Virus (the virus which causes hepatitis) since the student is frequently exposed to blood. The vaccine consists of a series of 3 injections given into the arm at specified time intervals, and is 80-90% effective in producing immunity against the Hepatitis B Virus. Please discuss this recommendation with your physician. Sources for the vaccinations are listed below.

If you have any questions regarding this requirement for admission, please contact your Program Coordinator at 414-297-6263.

HEPATITIS TESTING:
Hepatitis B Virus testing can be done at many locations. Please check your insurance coverage since some policies may cover partial payment. Several suggested locations are listed below:

- Your private physician or laboratory
- Public health departments
- City resource number 866-211-3380

IMMUNIZATIONS:
Hepatitis B Immunizations can also be done at various locations. Please check your insurance policy, since some policies will cover this cost in part or in full. Several suggested locations are listed below:

- Your private physician
- The public health department in your community
- City resource number 866-211-3380
# Verification of Hepatitis B Virus (HBV) Status: Blood Test Results (7A)

I, ________________________________ (Student name) and ID # __________________________ have had a Hepatitis B Virus blood test per requirement of the MATC Dialysis Technician Program. This test is a combined HBV antigen AND antibody test. The results of the tests are:

The results of the **HBV Antigen** Test are: (check one, please)

- The student tests **Negative** for Hepatitis B Surface Antigen.
- The student tests **Positive** for Hepatitis B Surface Antigen.

AND

The results of the **HBV Antibody** Test are: (check one, please)

- The student tests **Negative** for Hepatitis B Virus Surface Antibody.
- The student tests **Positive** for Hepatitis B Virus Surface Antibody.

Please include a copy of the lab report with this form.

These tests were performed on (date) __________________________

Physician Name (please print) __________________________

Physician Signature __________________________

Physician Address __________________________

____________________________

____________________________

____________________________

Physician Phone Number __________________________

---

**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 #: __________________________
Handbook Acknowledgement

School of Health Sciences
Student Handbook Signature Page

I acknowledge that I am responsible for the contents of the current School of Health Sciences Student Handbook located on the MATC website at:

http://www.matc.edu/student/Admissions/upload/Health_Sciences_handbook.pdf

I further agree to abide by the terms and conditions found in the contents of the current School of Health Sciences Student Handbook.

Student Signature: __________________________________________

Student Name: (Please print) ____________________________________

Student MATC ID Number: _____________________________________

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 #: __________________
ACCEPTANCE OF RISKS AND RESPONSIBILITY AGREEMENT
AND RELEASE OF LIABILITY

This Acceptance of Risks and Responsibility Agreement and Release of Liability ("Agreement and Release") is executed by: ___________________________ (please print student first and last name ("Participant") and is issued to ___________________________.

Participant is participating in a COLLEGE affiliated Program/Course/Practicum/Training/Activity ("Activity"). This Activity is more fully described in each of the MATC School of Health Sciences program pages, which have been provided to Participant.

Participant understands that there are certain dangers, hazards, and risks inherent in the Activity. These include, but are not limited to, contact with sharp, contaminated medical instruments, contagious diseases, infectious blood and/or body fluids, electrical instruments, electronic devices or other risks associated with patient care/non-patient care and the particular site. In certain circumstances, these dangers can include damage/destruction to property, severe bodily injury, and even death.

Participant agrees to exercise reasonable care at all times with respect to Participant’s own safety and with respect to the safety of others. Participant agrees to abide by all rules, policies and procedures of the COLLEGE that are set forth in the Code of Conduct found in the COLLEGE’s Student Handbook, as well as any additional rules, policies and procedures of the location of the Activity. Participant has no health-related issues that would preclude or restrict participation in the Activity.

Accordingly, Participant, on behalf of him/herself, the Participant’s spouse (if applicable), the Participant’s heirs, assigns, related individuals and related entities, does hereby WAIVE, RELEASE, AND DISCHARGE the COLLEGE, including its Board of Trustees/Directors, administrators, officers, employees, teachers, agents and insurers, from any and all claims, causes of action, suits, damages, or liabilities sounding in negligence, which the Participant has, shall have, or may have in the future against the COLLEGE arising out of, based on, related to, or connected with, the Participant’s enrollment and participation in the Activity. This release of liability does not, however, apply to any intentional or reckless acts or conduct by the COLLEGE.

This Agreement and Release shall be governed by the laws of the State of Wisconsin, which shall be the forum for any lawsuits filed under, or incident to, this Agreement and Release.

By signing this document, Participant acknowledges that s/he is fully informed of the contents of this Agreement and Release, and represents that s/he understands it. Participant is not relying on any oral or written representations, statements or inducements, apart from those made in this Agreement and Release.

Participant is at least eighteen (18) years of age, and is competent to sign this document. If Participant is a minor under the age of eighteen (18), the parent and/or guardian acknowledges they are competent to sign this document on behalf of the Participant.

By signing this Agreement and Release, you give up substantial legal rights. Read and understand this entire document before you sign it.

_________________________________________ (Participant)                                    __________   (Date)

_________________________________________ (Parent/Legal Guardian)                         __________ (Date)

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act (rev 7/2018)
CPR Verification:

American Heart Association 2 year Healthcare Provider level only.

Sign your CPR card and upload a copy of the FRONT and BACK of the card to castlebranch.com.
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.

<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>Dental Technician</td>
<td>Funeral Service</td>
<td>Registered Nursing</td>
</tr>
<tr>
<td>Dental Hygiene</td>
<td>Health Information Technology</td>
<td></td>
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<tr>
<td>Dental Technician</td>
<td>Health Unit Coordinator</td>
<td></td>
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<tr>
<td>Dental Technician</td>
<td>Healthcare Services Management</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Medical Assistant</td>
<td></td>
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<tr>
<td>Dental Technician</td>
<td>Medical Coding Specialist</td>
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<tr>
<td>Dental Technician</td>
<td>Medical Interpreter Technician</td>
<td></td>
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<tr>
<td>Dental Technician</td>
<td>Occupational Therapy Assistant</td>
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<tr>
<td>Dental Technician</td>
<td>Optician-Vision Care</td>
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<td>Dental Technician</td>
<td>Pharmacy Technician</td>
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<tr>
<td>Dental Technician</td>
<td>Phlebotomy</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Physical Therapy Assistant</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Radiography</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Renal Dialysis</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Respiratory Therapist</td>
<td></td>
</tr>
<tr>
<td>Dental Technician</td>
<td>Surgical Technologist</td>
<td></td>
</tr>
</tbody>
</table>

COMPLETE, INITIAL AND SIGN

**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 (rev 7/2018)
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: ___________________________
Drug Test Verification:

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

Student Signature: ______________________________________________________________________________________

Student Name: (Please print) _______________________________________________________________________________

Student MATC ID number: ___________________________________________________________________________________

Signature Date: __________________________________________________________________________________________

(Upload this page only)
I acknowledge that I am responsible for the contents of the current School of Health Sciences HIPAA Training located on the MATC website.

1. HIPAA-Privacy Rule for Covered Entities
2. HIPAA- Security Rule for Covered Entities

I further agree to abide by the terms and conditions found in the contents of the HIPAA training courses.

Student Signature: ________________________________________________

Student Name: (Please print) ____________________________________________

Student MATC ID Number: _____________________________________________

Signature Date: _______________________________________________________

***Information to access the training will be provided by the program coordinator.***

**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 #: __________________
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

<table>
<thead>
<tr>
<th>SUMMARY OF MATERIALS TO BE COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Requirements</strong></td>
</tr>
<tr>
<td>❑ (1) Physical Examination Form</td>
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or call the MATC School of Health Sciences at 414-297-6263.