VERNON COLLEGE
VERNON · WICHITA FALLS
www.vernoncollege.edu

Vernon Campus
4400 College Drive
Vernon, TX 76384
940.552.6291

Century City Center
4105 Maplewood Ave.
Wichita Falls, TX 76308
940.696.8752

Skills Training Center
2813 Central Expressway E
Wichita Falls, TX 76302
940.766.3369

Sheppard Learning Center
426 5th Avenue, Suite 8
Sheppard AFB, TX 76311
940.855.2203

Seymour Learning Center
200 Stadium Drive
Seymour, TX 76380
940.889.3133

Name: _____ **Phone:** _____

Email Address: _____**Date Returned:**_____

Medical Assisting in Transition for 2019-2020

Thank you for your interest in Vernon College's **2019-2020 Medical Assisting** program. Medical Assisting for the upcoming year is in transition to become a credit program enabling students to apply for financial aid. The following items will need to be completed prior to acceptance. Please start checking off your checklist! Check the website or call in **August 2019** for official start dates and packet deadlines.

CHECK LIST: (Please check each item as it is completed)

1. Apply to Vernon College (www.applytexas.org) _____
2. Apply for Financial Aid (**https://fsaid.ed.gov/npas/index.htm**)
3. Complete the Medical Assisting Questionnaire _____
4. Attach a copy of your driver's license or state-issued picture ID _____
5. Update shot records with all current vaccinations (attach to application):
   - Tetanus (Td) within last 10 years _____
   - 2 doses MMR _____
   - Hepatitis B Series (**series of 3 shots must be completed by September 3, 2019**) _____
   - Varicella (proof of 2 vaccinations or note indicating had chicken pox as a child) _____
   - TB within the last 6 months prior to the beginning of the program. _____
6. Write 1 page essay on, "Why I want to be a Medical Assistant" _____
7. Take **reading, writing, math portion** of "Accuplacer" and attach score (minimum score 65)
   Call Testing Center (940) 696-8752, ext. 3278, to schedule. _____
8. Current CPR card for Healthcare Providers _____
9. Complete and sign Drug and Alcohol Policy _____
10. Read and sign Criminal Acknowledgement form
11. Complete Authorization for Criminal Background Search _____
12. Complete Policies and Liability form _____
13. Complete Confidentiality Agreement _____

If you have any questions about this packet or requirements, please contact:

Vernon College
Continuing Education
4105 Maplewood
Wichita Falls TX 76308
940 696 8752 ext. 3213

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Medical Assisting Questionnaire

(Please complete the following questionnaire. The more information we have on you the easier the selection process is for the program. If you need extra paper please feel free to add or write on the back of this sheet.)

Applicant Name: _____ Date: _____

Is this your **first time to apply** for the Medical Assisting program? **Yes No**
If No, when did you apply before? _____

Previous College or Technical Training? **Yes No**
If Yes, what kind of training/college and did you complete the training?

_____

_____

If No, please explain (ie, just graduated from high school, stayed at home with children, etc.)

_____

_____

Are you currently working? **Yes No**
If yes, Current Employer: _____
If no, Why? _____

Do you have any previous Medical Training/Experience: **Yes No**
If yes, _____

Please describe your support network. Who is your biggest champion? What arrangements have you already made to make it possible for you to go to school? (daycare, work, tuition, etc.)

_____

_____

_____

_____

_____

Important!

Copies are your responsibility - keep your originals

VERNON COLLEGE
CONTINUING EDUCATION

DENTAL ASSISTING, MEDICAL ASSISTING, NURSE AIDE, PHLEBOTOMY CERTIFICATION

MUST PROVIDE SHOT RECORDS UPON ENROLLMENT

If you don't have your shot records, or shots need updating, see the Wichita Co. Health Department, 1700 Third Street, 761-7841. Please call Health Department for exact costs.

Students enrolled in health-related courses must have **all** the following vaccinations before they enroll in health-related higher education courses which will involve direct patient contact with potential exposure to blood or bodily fluids in educational, medical, or dental care facilities.

(1) **Tetanus-diphtheria.** One dose of a tetanus-diphtheria toxoid (Td) is required *within the last ten years*. The booster dose may be in the form of a tetanus-diphtheria-pertussis containing vaccine (Tdap).

(2) **Measles, Mumps, and Rubella Vaccines**.

(A) Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of two doses of a measles-containing vaccine administered since January 1, 1968 (preferably MMR vaccine).

(B) Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of one dose of a mumps vaccine.

(C) Students must show, prior to patient contact, acceptable evidence of one dose of rubella vaccine.

(3) **Hepatitis B Vaccine**. Students are required to receive a *complete series of hepatitis B* vaccine prior to the start of direct patient care or show serologic confirmation of immunity to hepatitis B virus.

(4) **Varicella Vaccine.** Students are required to have received one dose of varicella (chickenpox) vaccine on or after the student's first birthday or, if the first dose was administered on or after the student's thirteenth birthday, *two doses of varicella (chickenpox) vaccine are required.*

(5) **TB**, *within six (6) months*, prior to the start of program.

Students, who claim to have had the complete series of a required vaccination, but have not properly documented them, *cannot participate in coursework activities involving the contact* described in subsections (a) and/or (d) of this section until such time as proper documentation has been submitted and accepted.

The immunization requirements in subsections (b) and (d) of this section are not applicable to individuals who can properly demonstrate proof of serological confirmation of immunity. Vaccines for which this may be potentially demonstrated, and acceptable methods for demonstration, are found in §97.65 of this title (relating to Exceptions to Immunization Requirements (Verification of Immunity/History of Illness)). Such a student cannot participate in coursework activities involving the contact described in subsection (a) of this section until such time as proper documentation has been submitted and accepted.

Exclusions – Medical, Religious, Military: Persons submitting a signed affidavit from a licensed physician stating immunizations would be injurious to person's health (exclusion valid for one year); or from parents or legal guardians (if person is a minor) stating immunizations would conflict with the tenets of a recognized church or religious denomination of which the person is a member (exclusion not valid during times of emergency or outbreak); or persons who document to Vernon College they are currently serving on active duty with the armed forces of the United States are exempt from this requirement.

Waiver – Pregnancy: The following immunizations are required by law according to Section 2.09 of the Texas Education Code Revised effective May 16, 1999 for all students enrolled in higher education courses involved in direct patient care contact. Requirements for varicella, measles, rubella, and mumps vaccines are waived during pregnancy. Pregnancy is not a medical contraindication for administration of Tetanus/diphtheria toxoid, but it is best to delay until the second trimester. A student is required to provide a written note from physician stating they are not able to receive these vaccinations due to pregnancy. The student should also provide written documentation from their physician of any physical limitation they have for the duration of their enrollment in the course.

Revised 11.02.16

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VERNON COLLEGE
MEDICAL ASSISTING STUDENT POLICY
DRUG/ALCOHOL POLICY

IF THE STUDENT IS OBSERVED TO BE DISPLAYING BEHAVIORS* WHICH NORMALLY ARE DECIDEDLY DIFFERENT FROM THOSE BEHAVIORS NORMALLY DISPLAYED BY THAT STUDENT, OR OBSERVED TO BE DISPLAYING BEHAVIORS NOT CONSIDERED TO BE NORMAL BY USUAL STANDARDS, THAT STUDENT MAY BE REQUIRED TO SUBMIT THE APPROPRIATE SPECIMEN (URINE OR BLOOD) FOR LABORATORY TESTING.

*****Behaviors may include such things as: (list is not all inclusive)
slurred speech-impaired gait-repeated poor judgment-alcohol on breath-negligent patient care

If a test for drug or alcohol in the body reflects any level of drugs or alcohol, disciplinary actions will be taken.

I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE DRUG/ALCOHOL POLICY STATED ABOVE.

_____ _____

Signature **Date**

_____

Printed Name

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ACKNOWLEDGEMENT OF LICENSURE PERSONAL INFORMATION

Students with a previous criminal conviction or probation will not be permitted to participate in the Medical Assisting program. However, if you have any questions about your background and potential for licensure, students have the right to request a criminal history evaluation letter from the applicable licensing agency. Medical Assisting students may request this through National Healthcareer Association at info@nhanow.com or call 1-800-499-9020.

_____ _____

Signed **Date**

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_____ _____

Signed **Date**

Authorization for Criminal Background Search

Vernon College reserves the right to conduct a criminal background search of all applicants considered for employment, students participating in work programs, and students enrolled in certain programs of study.

The following information is required to proceed with the application process. By signing, you give Vernon College permission to have the Texas Department of Public Safety Crime Records Service conduct the search, and report all findings to Vernon College.

I give permission for a Criminal Background Search to be conducted and release the findings of the criminal background search to the health care agencies affiliated with the Medical Assisting program at Vernon College in order for me to provide patient care in those clinical facilities as a part of the Medical Assisting curriculum.

This search and the findings are strictly confidential and will not be shared with any other entity.

_____	_____
Full Name (please print)	Maiden Name (if any)
_____	_____
Other Name You Have Gone By (if any)	Date of Birth
_____	_____
Social Security Number	Driver's License Number
_____	_____
Signature	Date

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Policies Agreement and Waiver of Release from Liability

I, _____, hereby affirm, by my signature below, that I attest to the following:

1. I have received a copy of, have read, and do understand the Medical Assisting Course Requirements, Rules and Policies. I agree to abide by all the provisions therein. I understand that failure to comply will be grounds for dismissal with no refund.

2. I fully understand that due to the nature of the training that I shall receive, there exists the possibility of injury or infectious exposure to me, or injury or infectious exposure to others. I acknowledge and accept the fact.

3. I have been provided information from the Texas Department of State Health Services regarding Tuberculosis, have read and do understand it, and agree to follow the Tuberculosis procedures.

4. I have been provided information from the Texas Department of State Health Services regarding Universal Blood and Body Fluid Precautions for the prevention of HIV transmission in health care settings, have read and do understand it, and agree to follow the procedures.

5. I hereby release and agree to hold harmless Vernon College and the provider site facilities including but not limited to their trustees, administrators, coordinators, instructors, faculty, staff, and clients/patients/fellow students from any and all liability regarding aspects of Medical Assisting training.

6. This release shall extend to all locations considered part of the training.

7. I certify that I am 18 years of age or greater, and that I am legally competent.

Signature of Student Date

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Confidentiality Agreement

As a Medical Assisting student, I understand that during training I will come into contact with patients, and may have access to personal information regarding their names, health conditions, diagnoses and treatments, and information regarding the staff and policies of the clinical facility.

I hereby agree and affirm, by my signature below, that:

1. I will respect the confidential nature of all records, information regarding patients, and the rules and policies of clinical site(s); and

2. I will keep all such information STRICTLY CONFIDENTIAL; and

3. I will not discuss nor reveal any information in any way to any person; and

4. I will not violate the state and federal Right to Privacy Act(s); and

5. I will conform to all Policies, Rules, and Regulations of Vernon College, the Medical Assisting program, and the clinical site(s).

I understand that any violation of this Confidentiality Agreement may subject me to prosecution and can result in immediate dismissal from the course, with no refund.

I,_____, swear and affirm
(Print Full Name of Student)
that I have read the above and, by my signature below, do hereby agree to abide by all terms stated.

_____ _____
Date Signature of Applicant