

**Vernon College**  
**Health Information Management Program**  
**Application for Admission**

Date of Application: \_\_\_\_\_

**Demographic Information**

Name (Last, First): \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number (Home): \_\_\_\_\_ Cell: \_\_\_\_\_

Contact in case of emergency (Name/Phone): \_\_\_\_\_

Employer: \_\_\_\_\_ Type of work: \_\_\_\_\_

**Education History**

High School Attended (indicate GED if applicable): \_\_\_\_\_

College(s) Attended: \_\_\_\_\_

Degree(s) Earned/Major: \_\_\_\_\_

Have you applied to other Vernon College programs within the last 5 years? YES/NO  
(circle one) If yes, which one? \_\_\_\_\_ Accepted? YES/NO (circle one)

If declined, explain the reason \_\_\_\_\_

Were you declined based on a positive drug test? YES/NO (circle one)

Were you declined based on a negative background check? YES/NO (circle one)

## Consents and Disclaimers

### *Student Handbook & Disclosure*

I have received a copy of the HIM Student Handbook. In accordance with the established policies and procedures, I agree to use the HIM Handbook as a guide and to abide by the same, while enrolled in the HIM program. The HIM Handbook is subject to revision. If a revision occurs, the student will be notified in writing. I agree to all the information regarding Background Checks, Immunizations and the Clinical Hours required for the HITT 2361 class.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent for Release of Information

I, \_\_\_\_\_, give consent for Vernon College to do a mandatory criminal background check as required by clinical affiliates as a common practice and condition for clinical experiences. I understand that once this information has been attained that it will be provided for filing in the Program Director's Office and as required by facilities where this is a program agreement. Furthermore, this information will not be shared with other clinical facilities, persons or school officials unless prior notice has been given by me. It is further understood that provision of this information is required as part of the contractual agreement between Vernon College and the clinical affiliates. Furthermore, I understand that information from my file may be included in group data regarding the HIM Program. The information will only be provided as aggregate data and nothing will reveal individual names or specific individual information.

Printed name: \_\_\_\_\_

Signature/Date: \_\_\_\_\_

### Consent for Photo/Video Release

I hereby authorize Vernon College, hereafter referred to as "Company," to publish photographs taken of me, and my name and likeness, for use in the Vernon College's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Vernon College from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Vernon College, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Confidentiality Agreement

I, \_\_\_\_\_ agree not to disclose either verbally or through written word any part of the client's medical records or medical condition without written permission of the client (or designee, as applicable). This agreement is in effect in any clinical agency where I have access to client information. I understand that protection of the client's right to privacy is my responsibility.

Printed name: \_\_\_\_\_

Signature/Date: \_\_\_\_\_

## Consent for Drug Testing and Authorization for the Release of Test Results

I, \_\_\_\_\_, realize that part of the requirements for the HIM Program is routine drug screenings required by several affiliating agencies. The cost of the testing will be borne by the student. I further realize that a positive test result may deem me ineligible for admission to or progression in the Program. Once I am admitted into the Program, I may be subject to future drug screens in the event that "for cause" behavior (suspicious in nature) is demonstrated in the classroom or clinical areas or per agency/clinical requirement. This can be cause for withdrawal from the program with an "Incomplete" grade and referral to a substance abuse program. This can also impact my ability to meet clinical objectives and program outcomes. A report of the incident will be placed on file in the Offices of the Dean of Students and the Director of the HIM Program. I will be required to follow the policies outlined in the Vernon College Student Code of Conduct.

Printed name: \_\_\_\_\_

Signature/Date: \_\_\_\_\_

By signing below, I agree to the following conditions:

The information given in the application is factual. I understand that knowingly submitting false information is subject to a penalty of removal from consideration for the program, or removal from the program. I further authorize the Health Information Management program to obtain copies of my transcripts received by Vernon College and/or other records relevant to admission to the program. I have read, and agree to the terms of the Vernon College HIM program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Vernon College does not discriminate on the basis of race, color, religion, age, sex, national origin, disability or veteran status.