VERNON COLLEGE
MEDICAL ASSISTANT

New Student Application Packet
2022 - 2023

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

Dear Student,

Thank you for your interest in the Vernon College Medical Assistant Program. This program is an intensive nine-month night program that will prepare you to become a Certified Clinical Medical Assistant (CCMA) and Certified Phlebotomy Technician (CPT). Upon successful completion of the program, you are eligible to take the CCMA and CPT exams which are required to work in those areas in the state of Texas. These certifications can be used anywhere in the United States.

Applicants must apply and be accepted by Vernon College before being considered for admission into the Medical Assistant Program. The Medical Assistant Program is a selective admissions program. Upon application submission, applicants will be interviewed by the Program Instructor. All applicants will be given equal consideration for admission based upon the number of applicants and the applicant's completion of the application process.

You will need to follow the program requirements in order to be considered for the Medical Assistant Program. Please read all the information contained in this application packet and complete all required forms. There is a checklist provided to assure that you have completed all necessary forms and steps. This packet contains information that will be discussed during the interview with the Program Instructor.

If you have any questions about this packet or the application process, please contact Adrianna Caballero, Program Instructor at 940.696.8752 extension 3736 or by email at acaballero@vernoncollege.edu. You may also contact Karen McClure, Allied Health Faculty Assistant, at extension 3377.

Please make sure to write down the best way to contact you as that is how I will reach out to schedule your interview. I am excited about your interest in the program and I look forward to meeting you!

Adrianna Caballero, CCMA, CPT, CET
Medical Assistant Program Instructor

Medical Assistant Program
Checklist for Application Submission

Deadline to return packets is June 30th, 2022 at 5:00pm

Completed Application packets must be submitted in person to:
Vernon College – Century City Center **Office 704**
4105 Maplewood Ave Wichita Falls, TX 76308

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 Assistant Program Questionnaire _____
4. Attach a copy of your driver's license or state-issued picture ID _____
5. 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 4, 2020) _____
   - Varicella (proof of 2 vaccinations or note indicating had chicken pox as a child) _____
   - TB test (within 6 months prior to start of the program) _____
6. Take **reading, writing, math (arithmetic) portion** of "NexGen" and attach score
   TSI2 Assessment Scores are not required but will be accepted
   Call Testing Center (940) 696-8752, ext. 3278, to schedule. _____
7. Write a 1-page essay on "Why I Want to be a Medical Assistant" _____
8. Physical Exam (Dr. to complete Medical Assistant Student Physical Examination form) _____
9. Copy of current CPR card for Healthcare Providers _____
10. Complete a criminal background check and drug screen through CastleBranch (https://portal.castlebranch.com/VE93) _____
11. Complete Policies and Liability form _____
12. Complete Confidentiality Agreement _____
13. Complete Statement of Student Responsibility _____

Incomplete applications, applications returned after the assigned deadline, or applicants not meeting program entry requirements, will not be considered for admission into the program.

Name: _____ Phone:_____

Email Address: _____ Date Returned:_____

Medical Assistant Program Questionnaire

Applicant Name: _____ Date: _____

Is this your first time to apply for the Medical Assistant 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?
_____
_____

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

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

Why have you chosen the Medical Assistant Program?
_____
_____
_____
_____

In addition to hands on training, there will be many hours devoted to reading and studying. Do you think this is an area that you can excel in? Yes No
If not, how would you work around this?
_____
_____
_____

Many medical offices are digital (their scheduling, patient files, charting). This requires that you have computer skills. Can you navigate a computer and quickly learn a medical office management software system? Yes No

This program will give you the training necessary to enter the medical assisting profession. We do not guarantee employment. What do you hope to get out of this program?

_____
_____
_____

Clinicals are a vital part of your education and training. It is very important that you have the ability to follow instructions and to communicate effectively during your clinical training/observation. You will be required to complete 112 hours of clinicals during an eight (8) week semester with little or no make-up time available if you miss your hours. You will be interacting with doctors, medical assistants, nurses, and business/front desk personnel. Describe the qualities that you have that will help you complete your clinical hours.

_____
_____
_____

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.)

_____
_____
_____

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

Statement of Student Responsibility

Review and initial each section as verification that you have read and understand this information.

_____ I accept full responsibility for submitting a complete application packet and understand that incomplete or missing forms and documents will disqualify my application. I also accept responsibility of informing the Vernon College Medical Assistant Program of any change in my status, address, telephone number, or other information that would affect my application status.

_____ I understand that all forms, immunization records, etc. submitted with my application packet or uploaded to CastleBranch will become the property of Vernon College and will not be returned nor photocopied for me. Therefore, I am responsible for keeping my own photocopies of these documents before I submit them.

_____I authorize the release of these records to any of my clinical sites which may request them.

_____I acknowledge that a criminal background check and mandatory drug screen are required prior to beginning the Medical Assistant Program. I understand that the results of these screenings become the property of the Vernon College Medical Assistant Program and will not be released to me or any other third party. I also understand that a positive drug screen will result in my immediate dismissal from the Vernon College Medical Assistant Program.

_____ I acknowledge that I must comply with classroom and clinical rotations requirements. If I am absent from classroom instruction or clinical rotations for physical or mental illness, surgery or pregnancy reasons for two or more consecutive days, I must present a written physician's release prior to returning to the Vernon College Medical Assistant Program.

_____ _____
Applicant Signature Date

_____ _____
Program Instructor Signature Date

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

Confidentiality Agreement

As a Medical Assistant 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

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

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**

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

VERNON COLLEGE
MEDICAL ASSISTANT 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**

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

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

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

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 Assistant course requirements, rules and policies. I agree to abide by all the provision therein. I understand that failure to comply will be grounds for dismissal.

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 sites 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 dental 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 or have a legal guardian that will verify my understanding.

_____
Student/Legal Guardian signature

_____
Date

Vernon College Medical Assistant
Student Physical Examination

Name:_____ Date:_____
Address:_____ Telephone:_____

Age: _____
Height: _____
Weight: _____
Temp: _____
B/P: _____
Allergies: _____

Past History: Illnesses, operations and injuries (complete with dates): _____
_____

Indicate medications presently being taken that are prescribed by a physician: _____
_____

Indicate medications presently being taken that are not prescribed by a physician: _____
_____

Eyes:
Vision: R_____ L_____
With Glasses: R_____ L_____

Ears:
Condition: R_____ L_____
Hearing: R_____ L_____
Nose:_____
Sinuses: _____
Teeth: _____
Tonsils:_____
Thyroid: _____
Skin:_____
Abdomen:_____
Hernia:_____
Heart:_____
Lungs:_____

Feet:
R_____ L_____

Varicose Veins:_____
Posture: _____
Spinal Curvature: _____

Reflexes: _____

Defects found:_____

Corrections made or recommended:
_____
_____
_____

In your opinion, is this individual psychologically and physically capable of performing the direct client care required in dental assisting education?
( ) NO ( ) YES
If not, why?
_____
_____
_____

In your opinion, is this individual free of any communicable disease that would be detrimental to the patient while performing direct patient care?
_____

If no, explain:
_____

Name (print):_____
Licensed Health Care Provider's Signature: _____
Address:_____
Phone Number:_____