**INSTRUCTIONS**

Every Allied Health Program has Clinical Requirements with different cover pages.  
Please find your program below and see what is required so you can print the correct forms. 
Once you find your program below, please print off the required forms.

Please make sure you make copies of all forms or documents before submitting to the Clinical Admissions Coordinator.

<table>
<thead>
<tr>
<th>Program</th>
<th>Nursing</th>
<th>Phlebotomy</th>
<th>Med Tech</th>
<th>Paramedic</th>
<th>Surg Tech</th>
<th>Respiratory Care</th>
<th>PTA</th>
<th>GRN</th>
<th>Patient Care Tech</th>
<th>Massage Therapy</th>
<th>EMT</th>
<th>Dental Assisting</th>
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</table>
Criminal Background Checks: To comply with the requirements of accrediting organizations, clinical/field placement partners, and State and Federal laws governing licensing, HGTC students are required to have acceptable criminal background checks (CBC) and/or urine drug screening (UDS) and/or appropriate health information/immunizations to participate in placement(s) at clinical and field facilities. Typically, these checks and proof of health information/immunizations must be provided prior to the start of the first semester requiring clinical/field placement. **NOTE: Should your enrollment be interrupted (i.e. you miss a semester), new results for background checks, urine drug screening and/or health/immunization will be required. All fees and costs associated with any checks, screenings or immunization are the responsibility of the student.**

Admission to any of the programs listed below is conditional. Unsatisfactory results on the criminal background check or urine drug screening, or failure to complete any required health/immunization standards WILL prevent enrollment or result in removal from enrollment in the program of study.

The following Programs require a criminal background check (CBC) and/or urine drug screen (UDS) along with Health Tracker Immunization Documentation:

### FAILURE TO READ ALL INSTRUCTIONS MAY RESULT IN A DOUBLE FEE AT YOUR EXPENSE!

**PACKAGE CODE CHART**

In addition to Health Tracker Immunization Documents, a Criminal Background Check and Urine Drug Screen MUST BE COMPLETED WITHIN 30 DAYS PRIOR TO THE START of clinical rotation EACH SEMESTER or upon request by the clinical site. After initial order, Recheck Package Codes are available for subsequent semesters for $81. Add “re” to your Package Code (For Example: HG13re):

<table>
<thead>
<tr>
<th>MAJOR</th>
<th>Semester</th>
<th>1st Clinical / Field Class</th>
<th>Package Code</th>
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<tbody>
<tr>
<td>Dental Hygiene</td>
<td>1st and 4th</td>
<td>DHG 151</td>
<td>HG37 (cost $112.00)</td>
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<tr>
<td><em>see note under Fees</em></td>
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<td>Diagnostic Medical Sonography</td>
<td>1st and 4th</td>
<td>DMS 164</td>
<td>HG13 (cost $112.00)</td>
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<tr>
<td><em>see note under Fees</em></td>
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<tr>
<td>Emergency Medical Technician/Paramedic</td>
<td>1st</td>
<td>EMS 104 / 223</td>
<td>HG01 (cost $112.00)</td>
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<tr>
<td><em>see note under Fees</em></td>
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<td>Expanded Duty Dental Assisting</td>
<td>1st</td>
<td>DAT 154</td>
<td>HG51 (cost $112.00)</td>
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<td><em>see note under Fees</em></td>
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<tr>
<td>Massage Therapy</td>
<td>2nd</td>
<td>MTH 135</td>
<td>HG89 (cost $112.00)</td>
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<tr>
<td>Nursing</td>
<td>Every Semester</td>
<td>NUR 101 / 201</td>
<td>HG08 (cost $112.00)</td>
</tr>
<tr>
<td><em>see note under Fees</em></td>
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<tr>
<td>Patient Care Technician</td>
<td>2nd</td>
<td>AHS 163</td>
<td>HL13 (cost $112.00)</td>
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<td><em>see note under Fees</em></td>
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<tr>
<td>Phlebotomy</td>
<td>2nd</td>
<td>AHS 143</td>
<td>HG73 (cost $112.00)</td>
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<td><em>see note under Fees</em></td>
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<tr>
<td>Physical Therapist Assistant</td>
<td>Every Semester</td>
<td>PTH 234</td>
<td>HG70 (cost $112.00)</td>
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<td><em>see note under Fees</em></td>
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<tr>
<td>Practical Nursing</td>
<td>Every Semester</td>
<td>PNR 110</td>
<td>HG18 (cost $112.00)</td>
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**MAJOR**

<table>
<thead>
<tr>
<th>MAJOR</th>
<th>Semester</th>
<th>1st Clinical / Field Class</th>
<th>Package Code</th>
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<tbody>
<tr>
<td>Radiologic Technology</td>
<td>1st, 3rd and 5th</td>
<td>RAD 153</td>
<td>HG02 (cost $112.00)</td>
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<td>Respiratory Care</td>
<td>1st and 4th</td>
<td>RES 152</td>
<td>HN82 (cost $112.00)</td>
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<td><em>see note under Fees</em></td>
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<tr>
<td>Surgical Technology</td>
<td>1st and 2nd</td>
<td>SUR 101</td>
<td>HG05 (cost $112.00)</td>
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<tr>
<td><em>see note under Fees</em></td>
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**Criminal Background Check and/or Urine Drug Screen REQUIRED as indicated below:**

<table>
<thead>
<tr>
<th>MAJOR</th>
<th>Package Code</th>
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<tbody>
<tr>
<td>Sports Tourism</td>
<td>HH78 (cost $112.00)</td>
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<tr>
<td>Criminal Justice</td>
<td>HG63BG (cost $75.00)</td>
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<tr>
<td>Background Check ONLY</td>
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</tr>
<tr>
<td>Early Care and Education/Early Childhood Development Background Check ONLY</td>
<td>HG48BG (cost $75.00)</td>
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<td><em>See note below</em></td>
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<tr>
<td>Cosmetology</td>
<td>HG95 (cost $112.00)</td>
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<td>IMMEDIATELY upon admission</td>
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</tr>
<tr>
<td>Esthetics</td>
<td>HG04 (cost $112.00)</td>
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<tr>
<td>IMMEDIATELY upon admission</td>
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</tbody>
</table>

*IF YOU ARE REGISTERING FOR ECD 101 ONLY WITH NO OTHER COURSES IN THE ECD MAJOR, NO BACKGROUND CHECK IS REQUIRED*
FEES: There will be a non-refundable $75 criminal background check fee and $37 urine drug screening fee (in addition to any HGTC application fee). **All Nursing/Allied Health/Limited Access Students:** A criminal background check and urine drug screen must be completed no greater than 30 days prior to the start of clinical rotation each semester or upon request by the clinical site. All fees are paid to a third-party provider and, therefore, cannot be “billed” to the student.

STUDENT RESPONSIBILITY: Conviction of certain crimes may make a student ineligible to apply for licensure, ineligible to take certification examinations or ineligible for employment in certain fields. As such, HGTC reserves the right to disallow admission into certain programs of study if students are ineligible as defined by the guidelines listed here or others that may come into existence.

A Criminal Records Check (CRC), a check of the Sex Offender Registry, a check of the Office of Inspector General and a check of the General Services Administration (GSA) list of debarred contractors are required for admission and/or progression into a Health Sciences clinical course in designated programs.

The student MUST:

- Sign an Additional Admission/Placement Requirements Affidavit (Item #1). Return to admission office at one of the three campuses.
- Go online to [www.castlebranch.com](http://www.castlebranch.com) and order a criminal background check/urine drug screening. (Process outlined in detail in Item #2)
- Notify the College of any arrests or criminal charges filed against the student subsequent to completing this form; and any situations or incidents that occur after the background check/drug test has been purchased (including taking any illegal drugs). Failure to notify the College may result in dismissal from the program.
- Notify the College of any arrests or criminal charges filed against the student that are not appearing on the background check. Failure to notify the College may result in dismissal from the program.

Criminal Background Check Findings: Completed criminal background checks will be reviewed and indicated by a “Negative” or “Positive” result. If a negative criminal background check is returned by the vendor, the student will be considered to have satisfied that portion of the eligibility requirement for progression into clinical/field placement. (A clear urinary drug screening and completion of all required health forms and immunizations are necessary to establish full progression/placement eligibility).

Positive Result: If a “positive” background check is returned, the student will be notified to discuss the problem and will be required to provide additional information as part of the application, such as the terms or conditions of any plea, penalty, punishment, sentence, probation or parole; details regarding the offense; and the applicant’s reflections on the experience. If the student believes that the background check is in error and can provide documentation of records expunged or pardoned, then the background check will be reviewed by the department chairs and clinical partners to determine eligibility for clinical placement. If the student is unable to refute the background check finding(s), the student will be ineligible for progression into clinical/field placement.

Conviction of, plea of guilty, plea of nolo contendere (no contest), or pending criminal charges involving the following WILL bar admission to and WILL be grounds for dismissal from a clinical/field course of study:

- Crimes involving violence against the person, including, but not limited to: murder, manslaughter, use of deadly force, assault and battery of a high and aggravated nature, assault and battery with intent to kill, sex crimes, abuse of children or the elderly, abduction, robbery;
- Crimes occurring involving the distribution of drugs;
- Crimes occurring involving illegal use or possession of weapons, including, but not limited to: guns, knives, explosives or other dangerous objects;
- Crimes occurring involving dishonesty or moral turpitude, including, but not limited to: fraud, deception, embezzlement, financial exploitation, shoplifting, petit larceny, bad check; and
- Any other crime(s) or pattern of recurrent criminal or illegal behavior(s) will be reviewed on an individual basis.

Please note that Driving under the Influence (DUI) and Driving under Suspension (DUS) are NOT considered minor traffic violations. These patterns of behavior may result in withdrawal from the program of study.

Student must report to College any arrests and/or criminal charges or convictions filed subsequent to completion of the criminal background check as soon as possible but not later than seven (7) calendar days of such charge or conviction. Failure to do so may result in dismissal from the Program.
ADDITIONAL ADMISSION/PLACEMENT REQUIREMENTS AFFIDAVIT
(Required at the Time of Application to an Applicable Program of Study)

Certain programs of study at Horry-Georgetown Technical College carry additional requirements beyond regular admission and academic requirements before a student may either be placed into the program and/or be enrolled in a program specific class. Those additional requirements may include satisfactory completion of Criminal Background Check (CBC), Urine Drug Screening (UDS), and a health exam, physical, and/or immunization documentation. All costs associated with additional requirements are the sole responsibility of the student and in NO way the responsibility of Horry-Georgetown Technical College or its affiliates/partners.

Criminal Justice, Personal Care Services (Cosmetology and Esthetics), Early Care and Education, Machine Tool and Welding - Students MUST complete the CBC and/or UDS to be eligible for the programs listed (See Package Code Chart). Students required to complete CBC, who are under the age of 18 years, may be allowed to enroll in certain courses based upon this signed affidavit. However, upon 18th birthday the student will be required to complete a CBC to continue with the academic program. Any arrests, criminal charges filed, or offenses noted (recorded) against the student, subsequent to completing this form, may result in dismissal from the program.

Allied Health – Students may be allowed to enroll in certain courses required in programs requiring CBCs and UDSs based upon this signed affidavit. Students may enroll in general education courses or core program courses, which do not require agency or clinical placement. However, the student will be required to complete a CBC and UDS to continue with the allied health program prior to placement in any course in which the student will be attending or participating in outside agencies that require the CBC and UDS to be completed. An unsatisfactory CBC, UDS or health exam may disqualify the student from progressing in the program of study. Any arrests, criminal charges filed, or offenses noted against the student, subsequent to completing this form, may result in dismissal from the program.

Students failing to comply with the additional requirements, for his/her selected program of study, including completion a CBC, UDS and/or a health exam, physical, or immunization, through providing proof of successful completion on/before the published deadline, WILL be ineligible for admission, placement, or continuation in the program of study and/or clinical class(es).

Any student, other than ALLIED HEALTH, who has NOT been enrolled for two (2) consecutive semesters, MUST complete a new CBC. ALLIED HEALTH students MUST complete a new CBC and UDS every semester. ALLIED HEALTH students MUST complete a CBC and UDS no greater than 30 DAYS prior to the start of clinical rotation each semester or upon request by the clinical site. All fees and costs associated with any checks, screenings or immunizations are the sole responsibility of the student. Double fees at the student’s expense may result from the failure to comply with the requirements as stated on this form.

Certification of Understanding

I, __________________________, certify that I have read this statement and understand its implication on my current and future enrollment as a student at Horry-Georgetown Technical College, up to and including removal from any applicable class, course, and/or program of study for failure to comply with outlined additional requirements. In addition, I also certify that I will notify the College of ANY arrests and/or criminal charges filed against me NOT showing on the CBC or subsequent to completing this form; and any situation or incident that occurs after the Criminal Background Check (CBC) and/or the Urine Drug Screening (UDS) have been purchased (including taking any illegal drugs). I will also notify the College of any arrests or criminal charges filed against me that are not appearing on the background check. Failure to notify the College may result in disciplinary charges and dismissal from the program. In addition, I freely and voluntarily consent to the release of my Health Tracker immunization records, criminal background check, and urine drug screen to clinical and internship partners as it relates to my mandatory clinical rotation or field experience classes.

Student Signature

Date

Print Name

Date of Birth

Student ID Number (H#)
Student Instruction Sheet
Criminal Background Check/Drug Screening/Immunization & Health Records

**BEFORE PROCEEDING:** YOU MUST FIRST HAVE APPLIED AND BEEN ADMITTED TO AN APPLICABLE PROGRAM OF STUDY.

**NOTE:** All required steps in the background check process **MUST** be completed within the correct time period as indicated on the “PACKAGE CODE CHART” (pg. 1) or student may be withdrawn from classes.

**STEP 1: Create Account and Begin the Process**

1) Go to [www.castlebranch.com](http://www.castlebranch.com)
2) Enter Package Code based on your major in “Place Order” section (see Package Code Chart on page 1)
3) Click box next to “I have read, understand and agree to the Terms and Conditions of Use.” (please read statement first)
4) Click “Continue”
5) Complete all additional steps/forms, including payment

**STEP 2: Complete Urine Drug Screening (UDS)**

**Please NOTE:**
Instructions on how to complete your drug test are located in your Castle Branch account. Once you have logged in, go to the To-Do List titled "Drug Test" and click on the “Download Document” to print the UDS barcode.

You may complete your drug screening at any of the following LABCORP LOCATIONS:

<table>
<thead>
<tr>
<th>CONWAY LAB</th>
<th>MYRTLE BEACH LAB</th>
<th>MURRELLS INLET LAB</th>
<th>SURFside BEACH LAB</th>
</tr>
</thead>
<tbody>
<tr>
<td>812 Farrar Dr. Suite A</td>
<td>1021 Cipriana Dr. Suite 260</td>
<td>4017 Hwy 17 S, Suite 202</td>
<td>1945 Glenns Bay Rd</td>
</tr>
<tr>
<td>Phone: 843-347-8480</td>
<td>Phone: 843-497-6726</td>
<td>Phone: 843-651-3003</td>
<td>Phone: 843-650-8995</td>
</tr>
<tr>
<td>Hours: Monday-Friday*</td>
<td>Hours: Monday-Friday*</td>
<td>Hours: Monday-Friday*</td>
<td>Hours: Monday-Friday*</td>
</tr>
<tr>
<td>7:30am-12:30pm &amp; 2:00pm-3:30pm*</td>
<td>7:30am-12:30pm &amp; 2:00pm-3:30pm*</td>
<td>8:30am-11:30am &amp; 1:00pm-3:30pm*</td>
<td>8am-12pm &amp; 2pm-4pm*</td>
</tr>
</tbody>
</table>

* Hours of operation are subject to change. Please visit [www.labcorp.com](http://www.labcorp.com) to find a location near you!

**NOTE:** If you are currently taking any medications that will result in a Positive UDS, obtain a medication printout/list from your pharmacist and contact the Medical Review Officer at Castle Branch at 1-800-526-9341 to update your results.

**STEP 3: Submit Immunization/Health Records (if applicable to your major)**

**WHEN do I need to turn in my immunization/health records?** Students accepted into limited access programs (i.e. Nursing, Radiology, etc.) will receive information for submitting immunization/health records in the program acceptance letter. Students accepted into open enrollment programs will be advised for submitting immunization/health records by the program coordinator.

**WHERE do I need to turn in my immunization/health records?** All required immunization and health records must be submitted by one of the following ways:

1. **Drop off locations:**
   - Conway
   - Grand Strand
   - Georgetown
   Admission Office – Attention: Dana Mason Gasque
   Speir Building Room 1282-O – Attention: Dana Mason Gasque
   Admissions Office – Attention: Dana Mason Gasque

2. **Mail:**
   - Horry-Georgetown Technical College
   - Clinical Admissions Specialist – Dana Mason Gasque
   - Speir Building Room 1282-O
   - 3501 Pampas Drive
   - Myrtle Beach, SC 29577
   Dana.Gasque@hgtc.edu (please make sure all scanned documents are legible)

Please do not submit original documents, only copies! Please keep originals for your records!

*Questions or concerns please call or email Dana Gasque 843.477.2025 or Dana.Gasque@hgtc.edu.

Revised 10/14/2018 \ www.hgtc.edu
# Immunization Cost Estimate Sheet

(To Be Used as a Guide Only - Information is Subject to Change)

**Disclaimer:**
HGTC cannot be held responsible for the prices listed below.
It is the student’s responsibility to call and confirm availability, pricing, and insurance requirements.
HGTC is not affiliated with any of these providers regarding provision of healthcare services.
HGTC is unable to recommend any specific provider.

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Beach Urgent Care 843-626-2273</th>
<th>Carolina Health Pharmacy 843-215-8200</th>
<th>CVS Minute Clinic 866-389-2727</th>
<th>Doctor’s Care 843-238-1461</th>
<th>Little River Medical Center 843-663-8000</th>
<th>Med Plus 843-357-2443</th>
<th>Passport Health 480-646-9038</th>
<th>Southern Urgent Care 843-357-4357</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR Titer</td>
<td>$90.00</td>
<td></td>
<td></td>
<td></td>
<td>$40.00</td>
<td>$42.00</td>
<td>$35.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Varicella Titer</td>
<td>$40.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B Titer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$30.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculin Skin Testing (PPD) x 1</td>
<td>$25.00</td>
<td>$64.00</td>
<td>$28.00</td>
<td>$40.00</td>
<td>$42.00</td>
<td>$35.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>QFT Gold Test are Unacceptable</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-Ray with Positive PPD</td>
<td>$60.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$40.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>MMR Vaccine x 1</td>
<td>$115.00</td>
<td>$130.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$125.00</td>
</tr>
<tr>
<td>Hep B Vaccine x 1</td>
<td>$92.00</td>
<td>$140.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$96.00</td>
</tr>
<tr>
<td>Varicella Vaccine x1</td>
<td>$168.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$186.00</td>
<td></td>
</tr>
<tr>
<td>TDAP (Adacel) Vaccine</td>
<td>$64.00</td>
<td>$65.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$65.00</td>
</tr>
<tr>
<td>Flu</td>
<td>$28.00</td>
<td>$20.00</td>
<td>$32.00</td>
<td>$29.00</td>
<td></td>
<td></td>
<td>$20.00</td>
<td>$25.00</td>
</tr>
<tr>
<td>Physical Exam</td>
<td>$75.00</td>
<td>$79.00</td>
<td>$50.00</td>
<td></td>
<td></td>
<td></td>
<td>$100.00</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

Revised 10/02/2017 \ [www.hgtc.edu](http://www.hgtc.edu)
STUDENT CLINICAL PREPARATION ASSESSMENT

STUDENT NAME: ___________________________ STUDENT ID NUMBER: ____________

PROGRAM OF STUDY: ______________________ DATE: ___________________________

Please check YES or NO if you currently work or previously worked at any of the following hospitals or nursing homes:

YES NO
Conway Manor
Conway Medical Center
Georgetown Healthcare and Rehab
Grand Strand Regional Medical Center
Kingston Nursing Home
Lighthouse Care Center
McLeod (Seacoast, Loris, Florence, Etc.)
National Healthcare (NHC Garden City)
The Lakes at Litchfield
Tidelands (Waccamaw, Georgetown, Etc.)
Other (Please List): ____________________________

Please check YES or NO if you are prohibited from conducting clinical rotations at any of the following hospitals or nursing homes:

YES NO
Conway Manor
Conway Medical Center
Georgetown Healthcare and Rehab
Grand Strand Regional Medical Center
Kingston Nursing Home
Lighthouse Care Center
McLeod (Seacoast, Loris, Florence, Etc.)
National Healthcare (NHC Garden City)
The Lakes at Litchfield
Tidelands (Waccamaw, Georgetown, Etc.)
Other (Please List): ____________________________

HGTC INTERNAL USE ONLY:

HGTC (Faculty Name): ________________________ Date: _________________________
Confirmed With (Clinical Partner Personnel): ______________________________________
Comments: ____________________________________________________________________

Revised 10/02/2017 \ www.hgtc.edu
EXHIBIT 2

STUDENT CONFIDENTIALITY AGREEMENT
(Respiratory Care Program)

The following confirms an agreement between Apria Healthcare LLC ("Apria") and ___________________________(the “Student”), which is a material part of the consideration for the Student’s participation in an internship with Apria.

1. The Student understands that, during the term of his or her internship with Apria, the Student may acquire or have access to information that is the property of Apria and that is confidential and of great value to Apria (hereinafter called “Proprietary Information”). By way of illustration, but not limitation, Proprietary Information includes trade secrets, processes, formulas, data, know-how, software programs, improvements, inventions (whether patentable or not), techniques, marketing plans, strategies, forecasts, computer programs and other copyrightable material, the compensation and terms of employment of Apria employees, patient and customer lists, patient medical records and health information and other information concerning Apria’s actual or anticipated business or which is received in confidence by or for Apria from any other person.

2. In consideration of the Student’s internship with Apria, the Student hereby agrees as follows:

(a) All Proprietary Information shall be the sole property of Apria and its assigns. At all times, both during the term of the Student’s internship with Apria and after its termination, the Student will keep in confidence and trust all Proprietary Information and will not use or disclose any Proprietary Information or anything relating to it without the prior written consent of Apria, except as required by law or as necessary and appropriate in the ordinary course of performing the duties associated with the internship.

(b) All documents, charts, graphs, notebooks, customer lists, computer disks, tapes or printouts and other printed, typewritten or handwritten documents, whether or not pertaining to Proprietary Information (collectively, "Apria Material") furnished to the Student by Apria or produced by the Student or others in connection with the internship, shall be and remain the sole property of Apria. The Student agrees that, during his or her internship with Apria, the Student will not remove any Apria Materials from the business premises of Apria or deliver any Apria Materials to any person or entity outside Apria, except as required in connection with performing the duties of the Student’s internship. The Student further agrees that, immediately upon the termination of the Student’s internship with Apria for any reason, or during the Student’s internship if so requested by Apria, the Student will return to Apria all Apria Material, apparatus, equipment and other physical property (including all reproductions and copies thereof) in the Student’s possession or to which the Student may have access

(c) The Student shall comply with all of Apria’s policies and procedures regarding the confidentiality of patient medical records and health information.

I HAVE READ THIS STUDENT CONFIDENTIALITY AGREEMENT CAREFULLY AND UNDERSTAND AND VOLUNTARILY ACCEPT THE OBLIGATIONS THAT IT IMPOSES UPON ME, WITHOUT RESERVATION.

Date: ________________________________________  Student’s Signature

_____________________________________________  Student’s Name (Printed)
EXHIBIT 3

ACKNOWLEDGEMENT OF NON-COVERAGE BY WORKERS’ COMPENSATION INSURANCE
(Respiratory Care Program)

I, ________________________________________, understand that, as a Student, I am not covered under any workers’ compensation insurance maintained by Apria Healthcare LLC. I agree to indemnify and hold harmless Apria Healthcare LLC, and its parent, subsidiaries, and affiliates (collectively, “Apria”), and its employees and agents, from and against any and all loss, liabilities, and claims arising out of any injury that occurs in the course and scope of my internship with Apria.

Signature: ______________________________________

Name (Printed): ______________________________________

Date: ______________________________________

WITNESSED BY HGTC: ________________________________

Name (Printed): ________ Allan Dunphy or Sheri Tanner __________

Date: ______________________________________
Carolinas Hospital System
Student Hospital Orientation

Name (Please Print): ________________________________  Date ______________________________

Our primary objective is to make you feel comfortable and knowledgeable in your new surroundings.

Mission, Vision and Values

Standards of Performance Overview

Appearance

Communication

Hourly Rounding

CHS HIPAA Training

Security

Infection Prevention

General Safety

Fire Safety

Emergency Management

National Patient Safety Goals

Universal Protocol

Education Department Contact Information

The above topics have been reviewed and I have had an opportunity to ask questions. I understand that I am expected to observe and abide by these policies and practices during the course of my clinical experience at Carolinas Hospital System.

____________________________________  ______________________________________
Student Signature  Date
STUDENT CONFIDENTIALITY STATEMENT

Carolinanas Hospital System (Florence) provides a clinical site for students. As a student, I am aware of my responsibility to adhere to the policies of Carolinas Hospital System relating to confidentiality regarding patients’ medical records and information. I have received, reviewed and had the opportunity to ask questions regarding the confidentiality policies of Carolinas Hospital System.

I understand that medical records are the property of the hospital and are maintained for the benefit of the patient, medical staff and the hospital.

Information deemed as confidential includes inpatient medical records, discharged medical records, Emergency room records, outpatient records, records maintained by the Business Office, information maintained by the hospital information system (computer), and records maintained in all other departments.

I understand that any deliberate violation of the Confidentiality Policy may be grounds for termination of clinical rotation with Carolinas Hospital System.

________________________________________________________________________
Student Signature                                        Date

________________________________________________________________________
Title of Clinical Course and Number, School/Affiliate Program

________________________________________________________________________
Instructor
Carolinas Hospital System - Marion
STUDENT AGREEMENT

Name: ____________________________________________

Address: ____________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Phone Number: ____________________________________________

Date of Birth: ____________________________________________

University: ____________________________________________

Instructor: ____________________________________________

Clinical Rotation will be in _____________________________ Unit/ Department

From: ____________________________ to ____________________________

Date Date

- Students must wear a visible name tag designating student status.
- With each patient encounter the student must introduce themselves as a student and obtain permission to be present while confidential healthcare information is being shared.

I have read and understand this agreement. I will abide by the above rules requested by the Carolinas Hospital System – Marion during my student rotation.

Student Signature: ____________________________ Date: ____________________________

CHS-Marion Representative: ____________________________ Date: ____________________________

For Office Use Only:
Sanction Check: □ Passed  □ Rejected
Sanction Check Performed by: ____________________________________________

Date: ____________________________________________

Actions Taken: ____________________________________________

File: Student Agreement
February 1, 2013
CHS - Marion provides a clinical site for students. As a student, I am aware of my responsibility to adhere to the policies of CHS - Marion relating to confidentiality regarding patients’ medical records and information. I have received, reviewed, and had the opportunity to ask questions regarding the confidentiality policies of CHS - Marion.

I understand that medical records are the property of the hospital and are maintained for the benefit of the patient, medical staff and the hospital.

Information deemed as confidential includes inpatient medical records, discharged medical records, Emergency room records, outpatient records, records maintained by the Business Office, information maintained by the hospital information system (computer), and records maintained in all other departments.

I understand that any deliberate violation of the Confidentiality Policy may be grounds for termination of clinical rotation with CHS - Marion.

________________________  ____________________________
PRINT First Name                Middle Name                Last Name

___________________________________  ____________________________
Student Signature                Today’s Date

Date of Birth  _____________________________  Social Security Number

Title of Clinical Course and Number, School/Affiliate Program

________________________
Instructor’s Name
Carolinas Hospital System - Marion
Student Orientation Confirmation

Name: ____________________________________________________________

Please print

Carolinas Hospital System – Marion is committed to providing students a positive learning experience during their clinical rotation at our facility. We want you to feel comfortable in your new surroundings. We strive to prepare you with the knowledge of our facility and its practices prior to your clinical stay here.

I have been educated through the South Carolina Student Passport on the following topics related to Carolina Hospital System - Marion: (Please check the following)

☐ Vision of CHS-Marion
☐ Services Offered at CHS-Marion
☐ Campus Rules – No Smoking – Parking Areas
☐ Community Cares
☐ Standards of Performance
☐ AIDET
☐ Patient Rights
☐ Confidentiality and Security Agreement (HIPAA)
☐ Security
☐ Culturally Competent Care
☐ Infection Control Practices
☐ Safety Issues
☐ Swing Bed Training
☐ Codes at CHS-Marion
☐ National Patient Safety Goals
☐ Lewis Blackman Act
☐ Errors, Complaints, Falls Reporting

This is to verify that I have read and am knowledgeable on the topics listed above. I have thoroughly read the course and understand Carolina Hospital System- Marion’s policies and procedures with regards to students on campus during their clinical rotation. I am prepared to abide by these rules and regulations and will respect the values in place at Carolinas Hospital System - Marion.

______________________________________________
Student Signature

______________________________________________
Date

6/10/2016
**Job Description**

**Date last Edited**: 12/28/2017  
**Position Title**: Clinical Rotating Student  
**Job Code**: N/A – not employed

**Department**: Varies  
**Dept. #**: n/a  
**Reports To**: Educational institution assigned Clinical Educator/Supervisor or CMC assigned clinical preceptor  
**Workers Supervised**: None  
**Effective Jan 1, 2018**

**Qualifications**

The CMC provider and Onboarding policy delineates specific detailed requirements for qualification and entry to clinical rotation at the organization.

The term “work” or any other term that is also used in this document that may typically be used in reference to employees and employment are used generically to indicate scope of assignment for clinically rotating students. These terms, this description nor anything else related to students in no way imply current or future employment by a student.

**Student Scope Summary:**

1. Rotating Students must be under the supervision of an Educational institution assigned Clinical Educator/Supervisor or CMC assigned clinical preceptor at all times while on premises in the capacity of rotating student. This relationship will be specifically determined and defined before beginning.

2. Rotating students may perform tasks and functions that are specifically prescribed by the educational institution and the organization in the orientation prior to and at the start of the rotation. The exact tasks and functions will vary from course of study type and semester level with the program. Failure to perform within the specific scope of the orientation may result in dismissal from privilege to clinically rotate at the organization. Students may not carry out clinical procedures that are considered out of scope for their role. For example RN Clinical procedures that are out of scope and will be communicated at the time of orientation (at the latest) include the following:
   - Administration of blood products.
   - Administration of chemotherapy.
   - Obtaining/witness informed consent.
   - Accepting verbal or telephone orders from a physician or their designee.
   - Review and acknowledge physician orders.
   - Administration of emergency drugs.
   - Interpretation of cardiac rhythms.
   - Programming of IV pumps, PCA pumps, or epidural infusions unless the student is under the direct supervision of the nursing instructor/preceptor.
   - A student may not add or delete an IPOC (interdisciplinary plan of care) and may not complete any patient education.

3. “NP”s and “PA”s will receive written verification of scope of practice from the medical staff office in the “privilege letter”

4. Students may have limited access to select patients or experiences dependent upon site needs.

5. Patients may request to exclude student experiences.

6. Department managers will communicate any limitations regarding patient assignments to the clinical instructors.

7. Students are required to strictly adhere to patient confidentiality and protect the security of patient records and patient data.

8. Students are only allowed to access the records of patients involved in their care experience.

9. The instructor must be immediately present if the student has not attained clinical competency in a procedure or technical skill.

10. The instructor will provide specific guidance about which skills may be performed independently.

11. Students will have their documentation reviewed for content and accuracy by the instructor.

---

**Student Name (Print)**  
HGTC  
**Name of Educational Institution (Print)**

**Student Signature**  
**Student ID #**
Please Print Your Information

NON-EMPLOYEES ID CARD AUTHORIZATION

SSN: ________________________________  DOB: ______________________________

Legal First Name: ____________________  MI: _____  Last Name: __________________

Preferred First Name: __________________  Name Suffix:  □ II □ III □ IV □ V □ Jr □ Sr

Gender:  □M  □ F

Address:__________________________________________

________________________________________________________________________

City: ___________________________  State:_______________  Zip Code: __________

County: ___________________________  Telephone Number :____________________

Cell Number: _____________________  School: __________________________________

Email Address:_____________________________

Start Date:_________________________  Stop Date: _____________________________

McLeod Department (for clinical rotation): ________________________________

Present or Past Employee of McLeod Health  _____ yes  _____ no

Location of Rotation: ____________________________________________

(Florence, Darlington, Dillon, Loris, Seacoast)

TO BE COMPLETED BY MCLEOD HUMAN RESOURCES:

Department Director: _________________Job Code #: _____________Cost Center #: ____________
South Carolina Passport Project

You will use careLearning to complete your required training before reporting to a hospital to begin clinical rotation. You can create a new account or re-use your existing account at: http://passport.carelarning.com.

Here is some supplementary information:

1. **When you begin this process, it will be easiest if you have access you to your email account (Wavenet Email), as the program will require you to verify your account during the process.**

2. You will purchase courses and have access to them for 365 days. The total cost is $10.00.

3. Your classroom will automatically be populated with the courses that are common to all students. However, in most cases you will be required to also complete education specific to the hospital that you are reporting to for clinical rotation. You will be able to add those to your classroom as you need them.

**Below are the 15 modules that need to be completed for Horry-Georgetown Technical College:**

<table>
<thead>
<tr>
<th>Abuse &amp; Neglect</th>
<th>Hazard Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDET</td>
<td>HIPAA</td>
</tr>
<tr>
<td>Bloodborne Pathogens</td>
<td>Isolation ad Standard Precautions</td>
</tr>
<tr>
<td>Culturally Competent Care</td>
<td>Lewis Blackman Patient Safety Act</td>
</tr>
<tr>
<td>Disaster Preparedness</td>
<td>Moving, Lifting and Repetitive Motion</td>
</tr>
<tr>
<td>Electrical Safety</td>
<td>• You will need to manually add these two modules:</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>• Tidelands, Conway, Grand Strand, Waccamaw (GHO)</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>• Tidelands Health – Ebola Prepareness</td>
</tr>
</tbody>
</table>

4. To be considered compliant in your state you must complete the courses each year no more than 365 days apart.

5. The school or hospital you report to may request that you re-purchase earlier than when your classroom expires so that you are compliant in your training for the full semester.

   (Example: If you completed the courses in October of last year, you may be required to take them again upon your return to school in August so that you will not expire mid-semester.)

6. Should you experience difficulty, please contact us at 866-617-3904 or email support@carelarning.com Monday-Friday 8am-6pm.

7. You are required to remit a copy of your completed Transcript to Dana.Gasque@htgc.edu.

Form 1 - Revised 10/02/2017 \ www.hgtc.edu
South Carolina Passport Project  
(DMS, RAD and SUR Only)

You will use careLearning to complete your required training before reporting to a hospital to begin clinical rotation. You can create a new account or re-use your existing account at: http://passport.carelearning.com.

Here is some supplementary information:

1. **When you begin this process, it will be easiest if you have access you to your email account (WaveNet Email), as the program will require you to verify your account during the process.**

2. You will purchase courses and have access to them for 365 days. The total cost is $10.00.

3. Your classroom will automatically be populated with the courses that are common to all students. However, in most cases you will be required to also complete education specific to the hospital that you are reporting to for clinical rotation. You will be able to add those to your classroom as you need them.

**Below are the 17 modules that need to be completed for Horry-Georgetown Technical College:**

<table>
<thead>
<tr>
<th>Module</th>
<th>HIPAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse &amp; Neglect</td>
<td>HIPAA</td>
</tr>
<tr>
<td>AIDET</td>
<td>Isolation ad Standard Precautions</td>
</tr>
<tr>
<td>Bloodborne Pathogens</td>
<td>Lewis Blackman Patient Safety Act</td>
</tr>
<tr>
<td>Culturally Competent Care</td>
<td>Moving, Lifting and Repetitive Motion</td>
</tr>
<tr>
<td>Disaster Preparedness</td>
<td>** You will need to manually add these four modules:</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>• Tidelands, Conway, Grand Strand, Waccamaw (GHO)</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>• Tidelands Health – Ebola Preparedness</td>
</tr>
<tr>
<td>Hazard Communications</td>
<td>• Carolinas HS Marion – Student Orientation</td>
</tr>
<tr>
<td></td>
<td>• Carolinas HS Florence – Student Orientation</td>
</tr>
</tbody>
</table>

4. To be considered compliant in your state you must complete the courses each year no more than 365 days apart.

5. The school or hospital you report to may request that you re-purchase earlier than when your classroom expires so that you are compliant in your training for the full semester.

(Example: If you completed the courses in October of last year, you may be required to take them again upon your return to school in August so that you will not expire mid-semester.)

6. Should you experience difficulty, please contact us at 866-617-3904 or email support@carelearning.com Monday-Friday 8am-6pm.

7. You are required to remit a copy of your completed Transcript to Dana.Gasque@hgtc.edu.
Congratulations on completing your AHA course! One last step will make it official—claiming your eCard. As a reminder, only you can claim your eCard at this time; it cannot be claimed by someone on your behalf.

Please follow these instructions to claim your eCard:

1. You will receive an email from ecards@heart.org with a link inviting you to claim your eCard online. 
   If you do not receive this email, please check your Spam or Junk folders prior to alerting your Training Center or Instructor. To try to prevent the email from being marked as Spam or Junk, please add the email address, eCards.heart.org, to your Address Book or Contacts in your email server.

2. The link within the email will direct you to the Student Profile webpage, which will be prepopulated with your first name, last name, email address, eCard code, AHA Instructor name, and Training Center information. Adding your phone number is optional.
   Please check that this information is correct. If it is not, please contact the Training Center directly.

3. Once you have confirmed that your information is accurate, you will set up a security question and answer to access your eCard(s) in the future.

4. After setting up your security question and answer, accept the terms and conditions of the site and click “Submit.”

5. You will be directed to fill out a brief survey about the AHA course you just completed. Your answers to these questions will help improve the quality of future AHA trainings.

6. After you complete the survey, your eCard will be displayed. You will have 3 options to view or print it:
   - **Save as PDF:** Upon choosing your preferred size to view, you can save your eCard to your computer for future use.
   - **QR Code:** For students with a QR code reader, you can access your eCard on a mobile device as needed.
   - **Printing:** Your eCard can be viewed as a PDF and can be printed either wallet size (2.5” x 3.5”) to be cut out or full size (8.5” x 11”) for easy filing.

Please note that if you do not claim your eCard, you will not be able to show proof of course completion to your employer. If your employer requires proof of completion, you can email them a copy from the eCard landing page.

After you have accessed your eCard, you will receive an email from the AHA confirming that your eCard has been claimed. You should save this confirmation email for your records.

You can view your eCard online through the AHA’s website, www.heart.org/cpr/mycards, at any time. Simply enter your first and last name and email address, or the eCard code found on your eCard.

Your employer can verify your eCard at www.heart.org/cpr/mycards to confirm issuance by a valid Training Center and Instructor aligned with that Training Center. Employers are only able to verify your card if you have completed steps 1-5.
CPR REQUIREMENT:

- Basic Life Support Certification for the Healthcare Provider by American Heart Association (AHA) or American Red Cross (ARC) only
- Requires successful completion of cognitive and skills demonstration for healthcare provider (Adult, Child, Infant, and Choking Skills)
- Must renew CPR certification every 2 years

<table>
<thead>
<tr>
<th>CPR Completion Date</th>
<th>Certifying Agency:</th>
<th>Instructor’s Initials</th>
<th>Expiration Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ AHA</td>
<td>☐ ARC</td>
<td></td>
</tr>
</tbody>
</table>

Certification:

Signature below indicates verification of above initials in student completion of stated CPR requirement

__________________________________________________________________________

Printed Name: __________________________ Signature: __________________________ Title (RN, NP, MD): __________________________

CPR Instructor Affiliation: __________________________________________________

NOTE: This form serves as temporary documentation for CPR. The student is responsible for remitting a copy of the BLS Card to the Clinical Admissions Specialist. Cards typically take 30 days to receive. If it has been more than 30 days, the student is responsible for following up with their BLS Instructor regarding the BLS Card.
CPR/BLS Vendors - Prices and Information Subject To Change

Class Must Be:
CPR/BLS (Basic Life Support) for Healthcare Provider

Horry-Georgetown Technical College - Continuing Education – Betty Turner, Program Manager
Cost: $69.00
743 Hemlock Avenue, Bldg. 200 Suite 108, Myrtle Beach, SC 29577 - 843-477-2079 or 843-477-2020
Betty.Turner@hgtc.edu

Dates of CPR classes can be found at www.hgtc.edu/jobtraining. Students must bring their own book and mask.

Advance Medical Transport, LLC - Richard “Ricky” Brock, BSHS, NRP/Training Officer
Cost: $45.00
875 Nicholas Street, Suite B, Murrells Inlet, SC 29576 - 843-903-4268 or 843-299-2279 or 843-340-0109
They teach full classes as well as individual skills assessments.
To register, please visit: www.ambulancemyrtlebeach.com

Students must register at least 1-week prior to the scheduled class and bring their own book.

Heart To Heart-CPR, LLC – Randy and Kim Armstrong
Cost: $40.00 (Materials Included)
843-999-8451 or 854-999-6609
Randal.Armstrong@att.net or KimArmstrong57@att.net

Andy Brown
843-957-0124
ambrownl2345@gmail.com

Charles “Chuck” Crabbe - Cost $50.00 (Materials Included)
270-498-2745
Contact: chuckcrabbe@yahoo.com or crabbecpr@yahoo.com

Dwayne Wright
843-251-7752 (Preferred)
Dwright8871@yahoo.com

Jacquelyn “Lee” Smith - Cost $75.00 (Materials Included)
843-274-0128
Contact: jacquelynLeeSmith@gmail.com

Joanne Clarey
843-545-3400 Ext. 3407
Contact: jclarey@georgetowncountysc.org
Tina Bussa - Cost - $40.00
Contact: bussatina@gmail.com

Students can also complete the online written portion of the BLS course through the American Heart Association at www.onlineaha.org (Heart Code BLS). Print your Part 1 Certificate once complete and contact an approved vendor to schedule your Part 2 Skills Assessment (see above and below for assistance). Remember to take the HGTC CPR/BLF Form with you so your instructor can complete it on your behalf. In addition to remitting a copy of your form immediately following class, you will also need to remit a copy of your BLS Card to Dana.Gasque@hgtc.edu. Cards can take up to 30 days to receive, so make sure your instructor completes your form on the day of class.

BLS for Healthcare Providers Skills Sessions

Grand Strand Regional Medical Center
Training Center ID: SC05817
2000 Coastal Grand Cir Suite 520
Myrtle Beach, SC 29577
USA
843-839-9933

Horry County Fire & Rescue
Training Center ID: SC20285
2560 Main St Suite 1
Conway, SC 29526-3756
USA
843-915-7289

https://www.horrycountyfirerescue.com

Midway Fire Department
Training Center ID: SC05971
112 Beaumont Dr
Pawleys Island, SC 29585-7589
USA
843-545-3620 cgilmore@gtycounty.org
http://www.midwayfirerescue.org

McLeod Regional Medical Center
Training Center ID: SC15248
555 E Cheves St
Florence, SC 29506
USA
843-667-2000

Pee Dee Regional CTC Training Center
ID: SC05608
1209 W Evans St
Florence, SC 29501-3406
USA
8436654671 carolinacenter@bellsouth.net
http://PDCTC.COM

Pee Dee Regional EMS Training Center
ID: SC15505
1314 W Darlington St
Florence, SC 29501-2122
USA
8436625771 www.pdrems.com
http://www.pdrems.com

Robeson Community College
Training Center ID: NC05367
US301 N & I-95
Lumberton, NC 28359
USA
910-272-3408
fwillia@robeson.cc.nc.us

Southeastern Regional Medical Center
Training Center ID: NC06011
PO Box 1408
Lumberton, NC 28359
USA
910-671-5805
pitman01@srmc.org

Revised 10/15/2018 \ www.hgtc.edu
## INFLUENZA FORM

*Influenza A/B; H1N1 Combination Vaccine*

<table>
<thead>
<tr>
<th>Injection 1 (Lot Number):</th>
<th>Date:</th>
<th>Initials:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Expiration Date:</th>
<th>Manufacturer:</th>
<th>Injection Site:</th>
</tr>
</thead>
</table>

### Certification:

Signature below indicates verification of above initials in administration of, or reporting of, documented result for Influenza Immunization(s).

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title (MD, NP, RN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Title (MD, NP, RN)</td>
</tr>
<tr>
<td>Signature</td>
<td>Title (MD, NP, RN)</td>
</tr>
</tbody>
</table>

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance
HEPATITIS B FORM

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Or

Hepatitis B Titer Result: _______________________ Date: _____________________ Initials: ____________

Or

Declination/Waiver (Must sign page 4 of HGTC Health Science Division - Student Health Record)

Certification:

Signature below indicates verification of above initials in administration of Hepatitis B immunization and/or titer result.

____________________________________________________________________________

Signature

____________________________________________________________________________

Signature

____________________________________________________________________________

Signature

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
- Titer result may be reported on this sheet but must be accompanied by lab result with reference range clearly designated.
MANDATORY HEPATITIS B VACCINE/DECLINATION

Instructions:

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement (if you have not completed the entire series, please check the first two boxes).

DECLINATION

☐ 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 informed of the opportunity 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 will make arrangements at that time.

SERIES IN PROGRESS

☐ * I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all three vaccinations as they are completed.

SERIES COMPLETED

☐ I have completed the series of three vaccinations (submit via immunization record or form 7)

Student Signature

H#  Date
PROFESSIONAL LIABILITY INSURANCE

Required For the Following Allied Health Programs:

Dental Assisting (DAT)    Phlebotomy (AHS 143)
Dental Hygiene (DHG)      Physical Therapy (PTH)
Diagnostic Medical Sonography (DMS)  Radiology Tech (RAD)
EMT/Paramedic (EMS)       Registered Nurse (NUR)
Licensed Practical Nurse (LPN/PNR)  Respiratory Care (RES)
Nursing Assistant (AHS 163)  Surgical Tech (SUR)

Visit www.hpso.com (*)
Select “Get a Quote – Apply Now”
Select “Individual” and “Continue”
Follow the prompts as a “Student”

Minimum Coverage: $1,000,000 each claim and $3,000,000 aggregate

You will receive an email confirming your application was submitted.
Within 24-48 hours, you will receive an email containing your actual Policy. You are required to remit a copy of your Policy to Dana.Gasque@hgtc.edu.

As of 10/15/2018, the Annual Premium was $35.00. Prices are subject to change.

(*) Students can choose a vendor of their choice; however, coverage amounts must be as stated above.

Revised 11/12/2018 \ www.hgtc.edu
MEASLES, MUMPS, RUBELLA (MMR) FORM

TITERS ARE REQUIRED
Titer results must be accompanied by actual lab results with scores and reference ranges clearly designated.

<table>
<thead>
<tr>
<th>Titer Result</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASLES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUMPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RUBELLA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If you previously completed the 2-dose vaccine and any of your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.

- If you did not previously complete the 2-dose vaccine and your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive the following immunizations:
  - If all 3 MMR or Measles or Mumps are **NEGATIVE** or **EQUIVOCAL**: Two (2) doses of MMR are required.
  - If Rubella is **NEGATIVE** or **EQUIVOCAL**: One (1) dose of MMR is required.

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer</th>
<th>Expiration</th>
<th>Injection Site</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Certification:

Signature below indicates verification of above initials in administration of MMR immunization and/or titer result.

________________________________________________________________________________________

Signature \hspace{3cm} Title (MD, NP, RN)

________________________________________________________________________________________

Signature \hspace{3cm} Title (MD, NP, RN)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

Form 8; Revised 10/15/2018 \ www.hgtc.edu
DIRECTIONS:

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed “Student Health Record” prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request. A copy of immunizations/titer lab results must accompany this form.

SECTION I (to be completed by student)

Name: ____________________________________________

(Last)   (First)   (Middle)

Other Name(s) Student Known As: ________________________________  Birthdate: ________________

Home Address: ____________________________________________

(Street)   (City)   (State)   (Zip)

Telephone: ________________________________________________

(Home)   (Cell)   (Work)

Past Medical History:

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubeola</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken pox (MD documented)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Mono</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive TB Skin Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Herpes Viruses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart murmurs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitral Valve Prolapsed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Bladder Abnormality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ALLERGIES: ____________________________________________

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach/Intestinal Abnormality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hay fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color blindness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worry or Nervousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis (specify: A,B,C,D,E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (explain below):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you answered “yes” to any question, please give dates and treatments:

________________________________________________________________________

________________________________________________________________________

Please list any other medical conditions not addressed above:

________________________________________________________________________

Please list all medications that you are currently taking:

________________________________________________________________________

Student Signature ______________________________ Date _______________________

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: ______  Weight: ______  Blood pressure: ______  Pulse: ______  Respiration: ______  Temp: ______

Corrected Vision:  RIGHT: 20/ ______  LEFT: 20/ ______

Hearing: (Please circle)  RIGHT: Normal  Impaired  LEFT: Normal  Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change and treatment of ALL findings - see below)

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
<th>System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td>Metabolic/Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
<td>Genitourinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Immunological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (including murmurs)</td>
<td></td>
<td></td>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td>Other (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. If you have answered “yes” to any item in A above, please complete the following: (Additional information may be provided on a separate page identified with student’s name).

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Restrictions/Limitations (Bending, lifting, pulling, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE

(PROGRAM NAME)

TECHNICAL STANDARDS OF THE DENTAL SCIENCES DEPARTMENT

The Dental Sciences Department is comprised of the Dental Hygiene and Expanded Duty Dental Assisting programs that require specific technical standards. These standards refer to all non-academic admissions criteria essential to participate in the program. In order to be considered, admitted, or retained in the program after admission, all applicants with or without accommodations must possess the following abilities:

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS
FOR ADMISSION AND PROGRESSION IN THE DENTAL SCIENCES DEPARTMENT

Applicants/students MUST be able to perform these essential functions. For those applicants requesting reasonable accommodations such as compensatory techniques and/or assistive devices, you MUST also be able to demonstrate the ability to become proficient in these essential functions.

If your ability to perform these essential functions depends on accommodations being provided, be advised that requests for accommodations must be presented to “Disability Services”, and must be accompanied by appropriate medical, psychological and/or psychiatric documentation to support this request. You may contact “Disability Services” at (843) 349-5249.
<table>
<thead>
<tr>
<th>ESSENTIAL FUNCTION</th>
<th>TECHNICAL STANDARD</th>
<th>SOME EXAMPLES OF NECESSARY ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Requirements</td>
<td>Must have use of both hands and dexterity in the fingers; body build must fit into dental operator’s stool; use of feet</td>
<td>Proper manipulation of dental instruments, materials, and dental handpieces; proper manipulation of foot pedals to activate handpieces and other dental equipment</td>
</tr>
<tr>
<td>Data Conception</td>
<td>Must have the ability to gather, classify, and interpret information regarding patients or things, must be able to carry out appropriate actions in relation to the data received.</td>
<td>Proper interpretation of data given in the medical history and coordination of patient treatment with regards to the data.</td>
</tr>
<tr>
<td>Color Discrimination</td>
<td>Must be able to differentiate various shades of colors in a limited environment and space in the oral cavity.</td>
<td>Recognition of changes in the oral cavity from normal to abnormal with regards to tissue color</td>
</tr>
<tr>
<td>Manual Dexterity/Motor Coordination</td>
<td>Must have excellent eye-hand coordination and manual dexterity</td>
<td>Manipulating dental instruments in a small area to discern changes in surface texture without causing tissue trauma, controlling pressure exerted by dental handpieces on dental tissue, dexterity required for instrument exchange</td>
</tr>
<tr>
<td>Physical Communication</td>
<td>Must be able to perceive sound</td>
<td>Talking to patients on the telephone, hearing commands through operator’s face mask, discerning blood pressure sounds through a stethoscope</td>
</tr>
<tr>
<td>Reasoning Development</td>
<td>Must be able to apply principles of logical or scientific thinking to define problems, collect data, establish facts, and draw valid conclusions</td>
<td>Interpreting knowledge that has been learned in the classroom towards patient treatment</td>
</tr>
<tr>
<td>Visual Acuity</td>
<td>Must be able to see minute, detailed shapes from a 2 foot distance</td>
<td>Identification of working ends of dental instruments and other dental implements</td>
</tr>
<tr>
<td>Language Development</td>
<td>Must be able to read and comprehend complex information; able to communicate the same type of information through speech and in writing</td>
<td>Communication to patients of technical information in a clear concise manner at an understandable level</td>
</tr>
<tr>
<td>Numerical Ability</td>
<td>Must be able to determine percentages, convert fractions, ratio, and proportions as well as basic mathematical skills</td>
<td>Calculation of percentages with regards to plaque indices, counting of teeth, calculation of fees and percentages of those fees</td>
</tr>
<tr>
<td>Form/Spatial Ability</td>
<td>Must be able to view in 3-dimensional relationships, distinguish subtle changes from one form or shape to another, discriminate intricate measurements</td>
<td>Visualize tooth morphology during cavity preparation, documentation of probe readings during oral examination and periodontal charting</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Personal Temperament</td>
<td>Must be able to maintain a professional attitude and appearance, deal with stress, adapt to change, and function and focus in an environment with multiple extraneous stimuli.</td>
<td>Progress through a rigorous, challenging curriculum that is stressful, while maintaining a professional attitude and appearance when treating patients in an open-bay clinic or dental office setting that will have some noise and interruption.</td>
</tr>
</tbody>
</table>

NOTE: Students with documented disabilities through “Disability Services” of HGTC should inform their Course Professor at the beginning of each course to allow for accommodations for testing, note taking, etc.

<table>
<thead>
<tr>
<th>Does the student have any restrictions/limitations?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how many weeks are restrictions/limitations in effect:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what date will the restrictions/limitations be lifted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, will the student be required to follow-up with your office:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, date of scheduled appointment for follow-up:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

__________________________
Print Name of Physician, Physician Assistant, or Nurse Practitioner

__________________________
Signature of Physician, Physician Assistant, or Nurse Practitioner

NOTE: Some allied health programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.
MANDATORY HEPATITIS B VACCINE/DECLINATION

Instructions:

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement (if you have not completed the entire series, please check the first two boxes).

DECLINATION

☐ 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 informed of the opportunity 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 will make arrangements at that time.

SERIES IN PROGRESS

☐ * I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all three vaccinations as they are completed.

SERIES COMPLETED

☐ I have completed the series of three vaccinations (submit via immunization record or form 7)

Student Signature ___________________________ H# ______________ Date ______________

Form 3a; Revised 10/02/2017 \ www.hgtc.edu
DIRECTIONS:

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed “Student Health Record” prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request. A copy of immunizations/titer lab results must accompany this form.

SECTION I (to be completed by student)

Name: ____________________________________________

(Last) (First) (Middle)

Other Name(s) Student Known As: ____________________ Birthdate: _____________________

Home Address: __________________________

(Street) (City) (State) (Zip)

Telephone: __________________________

(Home) (Cell) (Work)

Past Medical History: __________________

ALLERGIES: ___________________________________

<table>
<thead>
<tr>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td>Stomach/Intestinal Abnormality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken pox (MD documented)</td>
<td></td>
<td></td>
<td>Color blindness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Mono</td>
<td></td>
<td></td>
<td>Recurrent headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive TB Skin Test</td>
<td></td>
<td></td>
<td>Back problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Herpes Viruses</td>
<td></td>
<td></td>
<td>Organ transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Disease</td>
<td></td>
<td></td>
<td>Insomnia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td>Frequent Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart murmurs</td>
<td></td>
<td></td>
<td>Frequent Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mitral Valve Prolapsed</td>
<td></td>
<td></td>
<td>Worry or Nervousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td>Hepatitis (specify: A,B,C,D,E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td>Epilepsy/Convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Other (explain below):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Bladder Abnormality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you answered “yes” to any question, please give dates and treatments:

________________________________________________________________________

________________________________________________________________________

Please list any other medical conditions not addressed above:

________________________________________________________________________

Please list all medications that you are currently taking:

________________________________________________________________________

Student Signature ____________________________________ Date ____________________

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: _______ Weight: _______ Blood pressure: _______ Pulse: _______ Respiration: _______ Temp: _______

Corrected Vision: RIGHT: 20/ _______ Hearing: (Please circle)

LEFT: 20/ _______ RIGHT: Normal  Impaired  LEFT: Normal  Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change, and treatment of ALL findings - see below)

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
<th>System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td>Metabolic/Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose, throat</td>
<td></td>
<td></td>
<td>Genitourinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Immunological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (including murmurs)</td>
<td></td>
<td></td>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td>Other (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. If you have answered “yes” to any item in A above, please complete the following: (Additional information may be provided on a separate page identified with student’s name).

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Restrictions/Limitations (Bending, lifting, pulling, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE

(PROGRAM NAME)

The following standards are considered essential criteria for participation in the Allied Health Programs. Students selected for Allied Health programs must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Allied Health Programs. In order to be admitted, or to be retained in the Allied Health Programs after admission, all applicants with or without accommodations must (by initialing the items you agree the student will be able to perform the function):

- Possess sufficient visual acuity to independently read and interpret the writing of all size.
- Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs through the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc.
- Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment, and perform other skills required in meeting the needs of nursing care.
- The student (Observer) is free of communicable illnesses

<table>
<thead>
<tr>
<th>Does the student have any restrictions/limitations?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how many weeks are restrictions/limitations in effect:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what date will the restrictions/limitations be lifted:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, will the student be required to follow-up with your office:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, date of scheduled appointment for follow-up:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

______________________________
Print Name of Physician, Physician Assistant, or Nurse Practitioner

______________________________
Signature of Physician, Physician Assistant, or Nurse Practitioner

NOTE: Some allied health programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.
MANDATORY HEPATITIS B VACCINE/DECLINATION

Instructions:

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement (if you have not completed the entire series, please check the first two boxes).

DECLINATION

☐ 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 informed of the opportunity 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 will make arrangements at that time.

SERIES IN PROGRESS

☐ * I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all three vaccinations as they are completed.

SERIES COMPLETED

☐ I have completed the series of three vaccinations (submit via immunization record or form 7)

Student Name: ________________________________
Student H#_____________________________
Program: ____________________________________

Student Signature ____________________________ H# ____________________________ Date ____________________________
Purified Protein Derivative (PPD) / Tuberculin Skin Test (TST) Form

**QFT Gold Blood Draws are unacceptable and therefore prohibited.**

*All information must be completed or it will not be accepted. PPDs must be read within 48-72 hours of administration.*

<table>
<thead>
<tr>
<th>PPD</th>
<th>Date/Time Given</th>
<th>Injection Site</th>
<th>Lot # &amp; Manufacturer</th>
<th>Expiration</th>
<th>Result</th>
<th>Induration</th>
<th>Date/Time Read</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Negative □ Positive</td>
<td>_____mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Negative □ Positive</td>
<td>_____mm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semester</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Negative □ Positive</td>
<td>_____mm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Step 1 and Step 2 are required for all Allied Health programs.
- Step 2 should be administered 7 days after Step 1 has been administered and/or read.
- Semester PPDs will be determined based on subsequent clinical site assignments.
- If PPD result is **POSITIVE** (>10 mm induration), student must provide proof of negative CXR.
- If **Positive** PPD – documentation from physician stating any further care is required.

**Certification:** Signature below indicates verification of above initials in administration of PPD/TST.

Signature: ____________________________________________________________

Signature: ____________________________________________________________

Signature: ____________________________________________________________

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
CHEST X-RAY FORM

(Required with 1st time positive PPD)

CXR Date: ___________ Result: ___________________________ Initials: ___________

NOTE: Copy of actual result must be attached. CXR result is valid for two (2) years.

If CXR is NEGATIVE, student must complete a SYMPTOM ASSESSMENT FORM (form 4c).

If CXR is POSITIVE, student will be referred to DHEC for treatment (if applicable) according to DHEC guidelines. Clearance from primary care provider is required for return to clinical setting if student was referred for positive CXR.

Certification:

Signature below indicates verification of above initials in administration of/and reporting result of CXR.

________________________________________________________________________
Signature Title (RN, NP, MD)

________________________________________________________________________
Signature Title (RN, NP, MD)

________________________________________________________________________
Signature Title (RN, NP, MD)

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance
SYMPTOM ASSESSMENT FORM
(Required Every Semester)

Instructions:
Complete this form ONLY if you had a Positive (+) Tuberculin Skin Test with a Negative (-) CXR.

Date: ______________ Date of Positive PPD: ______________ Date of Negative CXR: ______________

Have you been treated with tuberculosis medication? 
☑ Yes ☐ No

Have you ever received a BCG (tuberculosis vaccine)?
☑ Yes ☐ No

Have you been exposed to an isolated case of TB this year?
☑ Yes ☐ No

Do you have any of the following?

- Productive cough (> 3 weeks) ☐ Yes ☐ No
- Persistent weight loss without dieting ☐ Yes ☐ No
- Persistent low-grade fever ☐ Yes ☐ No
- Night sweats ☐ Yes ☐ No
- Loss of appetite ☐ Yes ☐ No
- Swollen glands in the neck ☐ Yes ☐ No
- Recurrent kidney or bladder infections ☐ Yes ☐ No
- Coughing up blood ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Chest pain ☐ Yes ☐ No

If you answered “YES” to any of the above questions, please explain:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

(Note: Clearance from a primary care provider, which may include repeat CXR, is required prior to clinical attendance if you answered “YES” to any of the above questions).

Student’s Signature: ______________________________ Date: ______________
Horry-Georgetown Technical College
Respiratory Care Program
Disclosure of Exposure to Potential Health Risks/Radiation Waiver of Liability

During the course of clinical or laboratory components of educational programs at Horry-Georgetown Technical College, students may come into contact with diseases, medicines, treatments, and equipment which are potentially hazardous to the student’s health, or to the health of an unborn fetus, in the case of pregnant students.

Exposures of potential hazards to which exposure may occur include, but are not limited to bacterial diseases (staphylococcal, streptococcal); mycotic disease (Coccidioidomycosis); tuberculosis; viral diseases (AIDS, Hepatitis); radioactive materials and radiation; It is possible that exposure to other hazards may occur, as well. Although reasonable efforts are made to avoid and minimize these risks, the exact probability of exposure to these potential hazards is not known.

Respiratory Therapy Students may be required to enter areas where access is restricted due to the storage, transfer, or use of radiation sources. Prior to extended work in these areas, students will be given appropriate instruction in precautions, protective devices, and educated about problems which may be encountered in these areas.

Students will be given instruction in infection control procedures, and other techniques for minimizing the risks of exposure to potential hazards. Once this instruction is provided, students will be expected to care for infected clients.

Because of potential health risks to both parent and unborn child, Horry-Georgetown Technical College recommends that pregnancy be disclosed as soon as possible by notifying the Program Director for information and assistance to lessen the risk to both mother and unborn child. Areas of concern are infectious/communicable disease, noxious fumes such as nitrous oxide, radiation and antineoplastic agents.

There is a higher risk of danger to students who have compromised immune systems. Immunosuppression occurs when the body’s ability to fight infections and other diseases is impaired due to inhibition of the body’s normal immune responses. Typical conditions which result in immunosuppression include HIV infection/AIDS, chemotherapy, steroid therapy, and anti-rejection drug therapy for organ transplantation. Students who suffer immunosuppression may consider withdrawing from the clinical program for so long as the immunosuppressive condition continues.

Each student enrolling in the Respiratory Care Program must read this disclosure and waiver before clinical instruction begins. Each student must complete the Waiver of Liability form and remit it to the Clinical Admissions Specialist.
WAIVER OF LIABILITY
RESPIRATORY CARE PROGRAM

I have received and read the attached Disclosure of Potential Health Risks. By participating in the clinical and laboratory program, I waive any and all claims and causes of action, present, and future, against the South Carolina Technical College System and their respective officers, agents, and employees out of my participation in clinical or laboratory program and resulting injury, physical or mental illnesses, disability, or death.

I acknowledge that this waiver is made freely, voluntarily and under no compulsion.

________________________________________  ________________
Student Signature                              Date

________________________________________  ________________
Print Student Name                             Date

________________________________________
Student ID Number

CC: Program Director

Revised 10/02/2017 \ www.hgtc.edu
# Tetanus, Diphtheria, Pertussis (TDAP) Form

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Booster</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Certification:**

Signature below indicates verification of above initials in administration of TDAP immunization and/or titer result.

_______________________________________________________________________

Signature
_______________________________________________________________________

Signature
_______________________________________________________________________

Signature

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
VARICELLA (CHICKENPOX) FORM

TITERS ARE REQUIRED

Titer results must be accompanied by actual lab results with scores and reference ranges clearly designated.

VARICELLA Titer Result: ________________ Date: _____________ Initials: _____________

- If you previously completed the 2-dose vaccine and your current titers are NEGATIVE or EQUIVOCAL, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.

- If you did not previously complete the 2-dose vaccine and your current titers are NEGATIVE or EQUIVOCAL, you are required to receive the 2-dose vaccine beginning immediately.

- Physician documented history of Varicella will not be accepted as proof of immunity.

<table>
<thead>
<tr>
<th>Injection</th>
<th>Lot #</th>
<th>Manufacturer:</th>
<th>Expiration:</th>
<th>Injection Site:</th>
<th>Date</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Certification:

Signature below indicates verification of above initials in administration of Varicella immunization and/or titer result.

____________________________________________________________________

Signature: __________________________ Title (MD, NP, RN): __________________________

____________________________________________________________________

Signature: __________________________ Title (MD, NP, RN): __________________________

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

Form 9, Revised 10/15/2018 \ www.hgtc.edu
WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

(Your initial Health Science Division – Student Health Record (form 3a) is valid for one semester. If you have had no changes in your medical history, you are eligible to complete this Waiver/Notification Form. If you have had any changes in your medical status, including new medications or any other additional change, continue reading below but do not sign this form. You are required to complete a new Health Science Division – Student Health Record (form 3a).

I, ________________________________, as a student enrolled in a Health Science Division Program at Horry-Georgetown Technical College, do hereby declare that I have sustained no changes in my physical health condition from my most recent student health examination required for the program.

- It is my understanding that in the event a physical health change occurs, it is my responsibility to immediately notify the following individuals of such change(s):
  1. Primary Course instructor and Clinical Instructor
  2. Clinical Admissions Specialist

- Following notification of health physical change(s), it is my responsibility to:
  1. Make an appointment with a healthcare provider for physical examination and completion of a new Health Science Division – Student Health Record (form 3a).
  2. Provide completed form 3a to the Clinical Admissions Specialist for verification of current eligibility for clinical without restrictions (specifically page 3 of health record).
  3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.

- If restrictions are indicated on the Health Record Form, the Clinical Admissions Specialist will notify the student’s designated Program Coordinator for guidance regarding further clinical continuation.

- In the event I fail to notify the appropriate individuals of such health changes, Horry-Georgetown Technical College is released from all liability relevant to my physical health status, and such failed actions on my behalf may result in dismissal from the program of study and/or constitute legal action thereof.

Printed Name

Signature

Date
# VACCINE ALLERGY/WAIVER FORM

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Contraindication to student receiving vaccine:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TST/PPD</td>
<td>Documented Allergy to Vaccine or Component of Vaccine</td>
</tr>
<tr>
<td>Influenza</td>
<td>Pregnancy  EDC: ____________________  Must be for live virus vaccine</td>
</tr>
<tr>
<td>TDAP</td>
<td>Date Vaccine can safely be administered ____________________</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Currently Immunosuppressed/Immunocompromised  Disease/Condition: ____________________</td>
</tr>
<tr>
<td>MMR</td>
<td>Date Vaccine can be safely be administered ____________________</td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
</tr>
</tbody>
</table>

- Certain health conditions/diseases are considered valid contraindications to vaccine administration.
- Pregnancy is not a contraindication to receiving inactivated vaccines such as: Hepatitis B vaccine, TDAP vaccine, or Flu vaccine (CDC Recommended Adult Immunization Schedule – United States 2010)
- Breast-feeding is not a contraindication for any vaccine, except smallpox (CDC, New ACIP Guidelines, May 2008)

**Certification:**

*Signature below* indicates *verification of above initials* in reporting of valid contraindication for student not receiving designated vaccine.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title (MD, NP, PA)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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