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>
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</tbody>
</table>

Revised 03/10/2019 \ www.hgtc.edu
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.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 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 Preparedness</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.
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:

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

<table>
<thead>
<tr>
<th>Abuse &amp; Neglect</th>
<th>HIPAA</th>
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</thead>
<tbody>
<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>Electrical Safety</td>
<td>• Tidelands, Conway, Grand Strand, Waccamaw (GHO)</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>• Tidelands Health – Ebola Preparedness</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>• Carolinas HS Marion Student Orientation</td>
</tr>
<tr>
<td>Hazard Communications</td>
<td>• MUSC Health Florence Medical Center Classroom</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.)

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

Form 1 - Revised 10/01/2019 \ www.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>
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<tbody>
<tr>
<td></td>
<td>☐ AHA</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>☐ ARC</td>
<td></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.
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 - 843-477-2020 or 843-477-2079
Betty.Turner@htgc.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/BLS 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@gtcounty.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
fgwillia@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
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: ________________________________

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<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
<th>Have you had?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
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<td>Stomach/Intestinal Abnormality</td>
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<td>Rubella</td>
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<td>Arthritis</td>
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<td>Mumps</td>
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<td>Asthma</td>
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<tr>
<td>Chicken Pox (MD documented)</td>
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<td>Hay fever</td>
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<tr>
<td>Infectious Mono</td>
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<td>Color blindness</td>
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<tr>
<td>Positive TB Skin Test</td>
<td></td>
<td></td>
<td>Recurrent headaches</td>
<td></td>
<td></td>
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<tr>
<td>Recurrent Herpes Viruses</td>
<td></td>
<td></td>
<td>Back problems</td>
<td></td>
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<tr>
<td>Sexually Transmitted Disease</td>
<td></td>
<td></td>
<td>Organ transplant</td>
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<tr>
<td>Heart disease</td>
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<td></td>
<td>Insomnia</td>
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<td>Heart murmurs</td>
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<td></td>
<td>Frequent Anxiety</td>
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<tr>
<td>Mitral Valve Prolapsed</td>
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<td></td>
<td>Frequent Depression</td>
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<tr>
<td>High Blood Pressure</td>
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<td>Worry or Nervousness</td>
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<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td>Hepatitis (specify: A,B,C,D,E)</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Epilepsy/Convulsions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Bladder Abnormality</td>
<td></td>
<td></td>
<td>Other (explain below):</td>
<td></td>
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</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>
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<tr>
<td>Ears</td>
<td></td>
<td></td>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Nose, throat</td>
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<td></td>
<td>Genitourinary</td>
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<tr>
<td>Neurological</td>
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<td>Skin</td>
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<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td>Immunological</td>
<td></td>
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<tr>
<td>Cardiovascular (including murmurs)</td>
<td></td>
<td></td>
<td>Psychiatric</td>
<td></td>
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<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td>Other (please explain)</td>
<td></td>
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</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>
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</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

Does the student have any restrictions/limitations?  
Yes _________  No _________

If yes, how many weeks are restrictions/limitations in effect: ____________________________

If yes, what date will the restrictions/limitations be lifted: ____________________________

If yes, will the student be required to follow-up with your office:  
Yes _________  No _________

If yes, date of scheduled appointment for follow-up: ____________________________

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  Date

__________________________________________________________________________  ____________
Signature of Physician, Physician Assistant, or Nurse Practitioner  Date

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
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: ________________________________________
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: _______ Respirations: _______ Temp: _______

Corrected Vision:  
RIGHT: 20/_______  Hearing: (Please circle)  
LEFT: ____/_______  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>
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</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.
### ESSENTIAL FUNCTION

<table>
<thead>
<tr>
<th>TECHNICAL STANDARD</th>
<th>SOME EXAMPLES OF NECESSARY ACTIVITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Requirements</strong></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>
</tr>
<tr>
<td><strong>Data Conception</strong></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>
</tr>
<tr>
<td><strong>Color Discrimination</strong></td>
<td>Must be able to differentiate various shades of colors in a limited environment and space in the oral cavity.</td>
</tr>
<tr>
<td><strong>Manual Dexterity/Motor Coordination</strong></td>
<td>Must have excellent eye-hand coordination and manual dexterity</td>
</tr>
<tr>
<td><strong>Physical Communication</strong></td>
<td>Must be able to perceive sound</td>
</tr>
<tr>
<td><strong>Reasoning Development</strong></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>
</tr>
<tr>
<td><strong>Visual Acuity</strong></td>
<td>Must be able to see minute, detailed shapes from a 2 foot distance</td>
</tr>
<tr>
<td><strong>Language Development</strong></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>
</tr>
<tr>
<td><strong>Numerical Ability</strong></td>
<td>Must be able to determine percentages, convert fractions, ratio, and proportions as well as basic mathematical skills</td>
</tr>
</tbody>
</table>
Form/Spatial Ability | Must be able to view in 3-dimensional relationships, distinguish subtle changes from one form or shape to another, discriminate intricate measurements | Visualize tooth morphology during cavity preparation, documentation of probe readings during oral examination and periodontal charting
---|---

**Personal Temperament**

| 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. | 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. |

**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

Date

__________________________

Signature of Physician, Physician Assistant, or Nurse Practitioner

Date

**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 ___________________________
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
Purified Protein Derivative (PPD) / Tuberculin Skin Test (TST) Form or QFT Gold Blood Assay

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

Form 4b: Revised 10/15/2018 \ www.hgtc.edu
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: _________________
**INFLUENZA FORM**

*(Influenza A/B; H1N1 Combination Vaccine)*

Injection 1 (Lot Number): _______________ Date: _______________ Initials: _______________

Expiration Date: _______________ Manufacturer: _______________ Injection Site: _______________

Certification:

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

______________________________
Signature                          Title (MD, NP, RN)

______________________________
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
## 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>
</tbody>
</table>

**Booster**

<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>
</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.
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>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</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.
MEASLES, MUMPS, RUBELLA (MMR) FORM

TITERS ARE REQUIRED

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

MEASLES Titer Result: ________________  Date: ___________  Initials: ___________

MUMPS Titer Result: ________________  Date: ___________  Initials: ___________

RUBELLA Titer Result: ________________  Date: ___________  Initials: ___________

• 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:
  o If all 3 MMR or Measles or Mumps are NEGATIVE or EQUIVOCAL: Two (2) doses of MMR are required.
  o 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>
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<tr>
<td>2.</td>
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</tr>
</tbody>
</table>

Certification:

Signature below indicates verification of above initials in administration of MMR 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.
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>
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<td></td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
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</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.
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](http://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](http://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): Dana Gasque, Roxanne Neumann, or Sheri Tanner

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
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
Carolinas Hospital System - Marion

Student Confidentiality Statement

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

_________________________________            Social Security Number
Date of Birth                   

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

________________________________________________________________________
Instructor’s Name

File: 2014 Student Confidentiality Statement
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: ______________________________________________________________________________________________________
STUDENT CONFIDENTIALITY STATEMENT

Carolinas 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
**Job Description**

<table>
<thead>
<tr>
<th>Date last Edited</th>
<th>Clinical Rotating Student</th>
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<tbody>
<tr>
<td>12/28/2017</td>
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**Position Title:**

Reports To:

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<thead>
<tr>
<th>Department:</th>
<th>Varies</th>
<th>Dept. #</th>
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Job Code:

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<th>N/A – not employed</th>
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**Reports To:**

<table>
<thead>
<tr>
<th>Reports To</th>
<th>Workers Supervised:</th>
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<tbody>
<tr>
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<td>None</td>
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</tbody>
</table>

**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:
   
   A. Administration of blood products.
   B. Administration of chemotherapy.
   C. Obtaining/witness informed consent.
   D. Accepting verbal or telephone orders from a physician or their designee.
   E. Review and acknowledge physician orders.
   F. Administration of emergency drugs.
   G. Interpretation of cardiac rhythms.
   H. Programming of IV/pumps, PCA pumps, or epidural infusions unless the student is under the direct supervision of the nursing instructor/preceptor.
   I. 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)**

**Student Signature**

**Name of Educational Institution (Print)**

**Student ID #**
I, the undersigned, hereby give my expressed written consent to Conway Medical Center to monitor my Email communications as well as all data, information, messages or communications of any type that are transmitted or stored on the Hospital’s computer system. I acknowledge and agree that said data, information, messages or communication which are transmitted or stored on the Hospital computer system, including Email, are Conway Medical Center’s records and property. Furthermore, I acknowledge and agree that Conway Medical Center’s system allows messages, once transmitted, to be printed, forwarded or disclosed by the receiving party without the consent or knowledge of the original sender of the message; and, therefore, I hold Conway Medical Center harmless in regard to the sending of any messages, when once transmitted, which may be printed, forwarded or disclosed by the receiving party without the consent of knowledge of me as the sender.

Furthermore, I agree that in using the Email system, as well as the Intranet/Internet system, that I will abide by and will operate within Conway Medical Center’s written policies and code of conduct guidelines. I agree that the internal and external Email systems are to be used for business purposes only on behalf of Conway Medical Center, and I acknowledge and consent that messages sent by employees, including myself, may be accessed at any time by the hospital in the ordinary course of its business without notice to me.

I agree that access to the Email system as well as to the Internet system is a privilege which may be revoked by the Hospital at any time and for any reason, and I acknowledge that Conway Medical Center reserves all right to any material stored in the files which are generally accessible to others and will remove any material which the Hospital, at its sole discretion, believes may be unlawful, obscene, pornographic, abusive or otherwise objectionable. I agree not to use Hospital resources to obtain, view, download or otherwise gain access to, distribute, or transmit such materials.

In executing this document, I hereby am entering into an agreement with Conway Medical Center wherein I agree and understand the following:

1. The Intranet/Internet and Email system and all information transmitted by, received from, or stored in these systems are the property of Conway Medical Center;
2. I have no expectations of privacy in connection with the use of these systems or with the transmission, receipt or storage of information in these systems, and I hereby give my express consent to Conway Medical Center or its designee to monitor the system and my usage thereof as well as all messages either sent by or to me on the Email system, and the said consent given herein to Conway Medical Center includes monitoring my usage of the system without giving me formal notice of said monitoring;
3. The Email and the Intranet/Internet systems may not be used to solicit or proselytize for commercial ventures, religious or political causes, outside organizations, or other non-job related solicitations;
4. The Intranet/Internet and Email systems may not be used to create or send any offensive or disruptive information or messages; and

5. The Intranet/Internet and E-Mail systems may not be used to send (upload) or received (download) copyrighted materials, trade secrets, proprietary financial information, or similar materials which are protected or may be protected under Federal, state and local laws without prior authorization.

I have received and read the written Intranet, Internet, and Email Usage Policy for Conway Medical Center and have agreed to be bound by each and every term, condition and provision contained therein. Furthermore, I acknowledge and agree that violation of any one of the said terms, provisions, and conditions contained in the said Internet Access policy for Conway Medical Center may result or be grounds for termination of my employment in accordance with Conway Medical Center’s written employment policies and procedures of which I also have received a copy and have reviewed.

I acknowledge and agree that I have no privacy rights relating to Intranet/Internet access and Email on the system. I agree and hereby give my expressed consent to Conway Medical Center that the information on these systems can be reviewed and read by Conway Medical Center at any time, as it deems necessary without notice being given to me. I agree and acknowledge that there is no guarantee or privacy while using these systems, and I further agree that these systems, telephone, computers and other communication devices are solely the property of Conway Medical Center and should and will be used by me strictly for business purposes only. Furthermore, I agree not to send any messages or utilize any materials on the system containing obscene, profane, lewd, derogatory, or otherwise potentially offensive language or images, and I acknowledge that the use of material containing racial, sexual, or similar comments or jokes is expressly forbidden.

Signature: ____________________________     Date: ___________________________

Form # HR-A-39 Student/Contract       Revised 12/04/2018/bmj
Confidentiality and Security Agreement Form #HR-A-23
(Student/Contract)

I understand that Conway Medical Center and its affiliate organizations, (hereinafter "CMC") in which or for whom I work, volunteer or provide services, or with whom the entity (e.g., physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information, CMC, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of its patients' health information. Additionally, CMC must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information "Confidential Information").

In the course of my employment/assignment or association with CMC, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with CMC's Privacy and Security Policies, which are available from CMC. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

- I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.

- I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.

- I will not discuss Confidential Information where others can overhear the conversation.

- I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.

- I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with CMC.

- Upon termination of any relationship with CMC, I will immediately return any documents or media containing Confidential Information to CMC.

- I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with CMC.

- I will act in the best interest of CMC and in accordance with its Code of Conduct at all times during my relationship with CMC.

- I understand that violation of this Agreement may result in the disciplinary action, corrective action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within CMC, in accordance with CMC's policies.

- I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

- I understand that I should have no expectation of privacy when using the CMC information systems. CMC may access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
• I will practice good workstation security measures such as locking up diskettes when not in use, using hospital approved screen savers with activated passwords appropriately, and position screens away from the public view.

• I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved standards.

• I will:
  a. Use only my officially assigned User-ID and password.
  b. Use only approved licensed software.
  c. Use a device with virus protection software.
  d. Contact the Information Technology department if my password is accidentally revealed to request a new password.

• I will never:
  a. Share/disclose user- IDs or passwords.
  b. Use tools or techniques to break/exploit security measures.
  c. Connect to unauthorized networks through the systems or devices.
  d. Install unauthorized software on hospital computer systems.

• I will notify my manager or appropriate Information Technology person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy, and security policies, or any other incident that could have any adverse impact on Confidential Information.

• The following statements are additional requirements for physicians using CMC systems containing patient identifiable health information (e.g., Meditech):

• I will only access software systems to review patient records when I have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to CMC at the time of each access that I have the requisite patient consent to do so, and CMC may rely on that representation in granting such access to me.

• I will only access patient information to the extent it is reasonable and necessary for me to treat a patient. The information that I review will be kept confidential, and I will only review so much of a patient's medical record as is necessary for me to render appropriate treatment. If I am given access to a patient's medical record due to a consult, emergency situation, or an on-call situation at which time I am not the patient's primary attending physician, I will only access that patient's information to the extent it is needed for me to render appropriate medical treatment. Under no circumstances will I access a patient's information without a patient's verbal or written consent or for whom I am not rendering medical treatment.

• I will ensure that only appropriate personnel in my office will access the CMC's software systems and Confidential Information and that I will annually train such personnel on issues related to patient confidentiality and access.

• I will accept full responsibility for the actions of my employees who may access the CMC's software systems and Confidential Information.

By signing this document, I acknowledge that I have read this agreement and I agree to comply with all terms and conditions stated above.
The link below will open our CMC Policy Manager so that you can review the assigned Student policies prior to your assignment date. We have provided a "guest" username and password for your convenience. This is not an exhaustive list of CMC policies, but ones we deem important to review prior to your assignment. You are asked to verify you reviewed these policies by initialing below.

https://cmc.ellucid.com/manuals/binder/467/8  Login: guestHRSW (case sensitive) – Password: conway (case sensitive)

<table>
<thead>
<tr>
<th>Initials/Completion</th>
<th>Title of HR Policy</th>
<th>Initials/Completion</th>
<th>Title of HR Policy</th>
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<tbody>
<tr>
<td></td>
<td>Exclusion from Patient Care</td>
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<td>Identification Badges</td>
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<tr>
<td></td>
<td>Dress and Appearance Standards</td>
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<td>Licensure</td>
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<tr>
<td></td>
<td>Drug Free Workplace</td>
<td></td>
<td>Solicitations</td>
</tr>
<tr>
<td></td>
<td>Code of Conduct (Ethics &amp; Professional Behavior)</td>
<td></td>
<td>Nicotine Free Organization</td>
</tr>
</tbody>
</table>

I understand that the organization utilizes multiple formats for distribution of policies. I had the opportunity today to personally review the list of policies noted above. During my onboarding process I will learn more about the applicability of certain policies to my work and overall assignment and how to access them at the organizational and department levels. Further I understand that I can contact the Human Resources Department should I have any questions or need assistance in accessing or understanding any aspects of these policies. And additionally, I understand that I may access these policies electronically or in paper copy format through the HR office at any time, and it is my personal obligation to periodically refresh on the policies to ensure my continual update and understanding. I also understand that should any substantive changes be made to these policies after my initial assignment date, my assigned department leader will summarize those changes and inform me of the renewed obligation to fully review the policy again. By signing below, I acknowledge this responsibility and agree to abide by the policies.

Additionally, I have received the CONWAY HOSPITAL, INC. GENERAL INFORMATION BOOKLET. I will read this information prior to and will be given the opportunity to ask questions during the onboarding process.

Name (Please Print)  Signature  Date

Equal Employment Opportunity - The organization will recruit, hire and train employees without regard to age, disability, race, color, sex, gender, genetic disposition, religion, national origin, sexual orientation or any other non-work related factor. The criteria for selecting, hiring, promoting, or judging applicants and making other employment/work related decisions are experience, education, training, skills, work/criminal background, turnover risk and other factors which may be related to the individual's ability to perform and stay on the job. We will also ensure that human resources related decisions and actions, including but not limited to compensation, benefits, transfers, promotions, demotions, layoffs, disciplinary actions, termination, job classification and all other terms, conditions and privileges of employment will be administered without regard to age, disability, race, color, sex, gender, genetic disposition, religion, national origin, sexual orientation or any other non-work related factor.

Sexual Harassment is prohibited and is unwelcome sexual advances for sexual favors, or other verbal, visual, or physical conduct of a sexual nature when that is unwelcomed and becomes an explicit or implicit condition of employment or; employment decisions such as promotions, transfers, compensation or corrective action are determined on the basis of the employee’s response to such conduct or; unwelcome sexual conduct by either an employee or non-employee interferes with an individual’s job performance or creates an intimidating, hostile or offensive work environment.

Hostile Environment Harassment is prohibited and occurs when there exists within the workplace discriminatory intimidation, ridicule, and insult that is sufficiently severe or pervasive to alter the conditions of an individual’s employment and creates a hostile or abusive working environment. To amount to a “hostile environment”, such conduct must create an environment that a “reasonable person” would find hostile or abusive.

Violence in the Workplace is prohibited and is defined as aggressive acts that include verbal threats to physical force, physically harming another to include but not limited to punching, pushing or shoving or the brandishing of a weapon with intent to injure, intimidate, harass, or coerce.

Reporting an Incident – A student who believes he/she has been subjected to inappropriate conduct by another within the work place should firmly and clearly tell the person engaging in the inappropriate conduct that it is unwelcome, offensive and he/she should stop at once. Also, such conduct should immediately be reported to the student’s immediate supervisor or department director. Incidents involving a student and his/her immediate supervisor should be reported directly to the Human Resource Department or through the Compliance Department hotline. All complaints regarding inappropriate conduct as defined within this policy will be thoroughly investigated in as confidential manner as possible. The organization strictly prohibits any employee accused of inappropriate conduct from retaliating against the person(s) bringing such a claim to the organization’s attention.

I have read this information above and had opportunity to ask questions and understand fully all aspects of the information. I fully agree to comply with the organizational policy and standards noted above.

_________________________  ______________________  ________________
Signature                   Printed Name                  Date

Revised 12/04/2018/bj
Statement of Understanding and Compliance with Organizational Code of Conduct Form #CC-01

☐ I certify that it is my responsibility to read the Code of Conduct and the Corporate Compliance Manual during the first 30 calendar days of my employment/assignment and agree to abide by it during the entire term of my employment/assignment.

☐ I understand that I will be oriented to the topic further during general orientation and I will be afforded time to ask questions during that session.

☐ I understand that at any time I may bring related questions or concerns forward without fear of reprisal or retaliation and the organization has a no tolerance position on retaliation against someone for reporting a concern.

☐ I acknowledge that I have a duty to report any alleged or suspected violation of the Code of Conduct or the Corporate Compliance Program through the leadership chain of command for my area, the Compliance Hotline Number shared with me or the Corporate Compliance Officer.

☐ I understand that I don’t have to be an expert in an area to have concerns, and it’s fine to bring forward any and all concerns and let the organization review for action needed.

☐ I will behave in an ethical manner and will comply with federal, state and local laws and regulations.

☐ I will comply with the Organization’s Patients’ Rights Statements, confidentially and HIPAA policies and all other Organization policies and procedures for which I am oriented to know or have education to understand.

☐ I won’t disclose pricing information to, or obtain such information from, a competitor of the Organization.

☐ I won’t offer or receive a kickback, gift, tip or anything to induce a person or entity to purchase services from the organization or refer patients to the Organization or place myself in a situation to have my decision making influenced.

☐ I will document truthfully, accurately, and completely, on all Organization records, reports, and forms and will avoid alteration with intent to falsify records.

☐ I will comply with all copyright laws and computer security policies.

☐ I will help protect the environment by complying with all environmental laws conserving natural resources.

☐ I won’t accept any gift or promotional item worth more than $100.00 from someone doing business with the Organization, and I won’t accept gifts of any value from patients or visitors on my personal behalf.

☐ I won’t disclose any patient information or non-public business information obtained to others who don’t have business need-to-know.

☐ As may be applicable, I will deal honestly and fairly with customers, suppliers, reviewing agencies, and payers, both government and private and I will avoid conflicts of interest.

☐ As may be applicable, I won’t delay the provision of a medical screening examination to determine the presence of an emergency medical condition in order to inquire about the patient’s method of payment or insurance coverage.

☐ As may be applicable, I won’t bill for any service knowingly not rendered or facilitate claims for non-covered services as if covered. I also won’t fail to report misuse of provider ID numbers.

☐ As may be applicable, I will select codes for diagnosis & services rendered based on education and training provided and will avoid unbundling of codes and utilize modifiers as required.

__________________________  __________________________
Date                                      Signature

__________________________
Print Name

__________________________
Position/Department
### Competency: Using the AIDET Communication Technique

**ACKNOWLEDGES** the patient.
- Smiles, makes eye contact and greets them in a pleasant manner.

**INTRODUCES** self:
- States name and position.
- Highlights skill and expertise of self and other healthcare team members
- “Manage up” co-workers, physicians, and departments.

**DURATION:**
- Gives the patient a time expectation.
- Keeps the patient informed as to the amount of time a procedure will take.
- Lets patient/family know if there is a wait time; gives time expectation of that wait.

**EXPLANATION:**
- Keeps patient informed by explaining all processes and procedures.
- Communicates clear expectation of what will happen.

**THANKS** the patient:
- Consistently thanks patients for their time and for choosing organization.
- Expresses appreciation that patient/family have chosen or as their health care facility/work place.
- Asks if there is anything else he/she can do for the patient before ending the interaction.

Ensures non-verbal communication conveys the AIDET principle:
- Makes eye contact.
- Respects patient’s personal space (as much as possible)
- Listens to what the patient is saying; allowing for silence; does not interrupt.
- Ensures body language is relaxed, open and non-threatening.
- Displays a calm manner.

I acknowledge and will comply with the above AIDET Communication Techniques.

---

**HIPAA TRAINING ACKNOWLEDGEMENT**

I have been informed about the Conway Medical Center HIPAA Privacy Program. I understand that it is my responsibility to review the policies online in Policy Manager. I understand that if I have any questions, I may contact my department manager and/or the hospital's Privacy Officer. I understand that complying with the Program is a condition of my assignment with Conway Medical Center.

---

Name (Signature)       Name (Print)       ID #       Date
Safety is one of our most important priorities at CMC. Red Rules, Behavior Based Expectations, and Error Prevention Techniques are tools we use to ensure the safety of our patients, visitors, and all staff.

By complying with established red rules, following behavioral expectations, and utilizing prevention tools and techniques, I make a conscious decision to help ensure the safety of patients and staff, and I am helping to create a culture of safety at CMC.

**Conway Medical Center Red Rules**

1. I will always wash my hands or use hand sanitizer before and after every patient contact.
2. I will verify patient identity using two identifiers prior to any action or procedure.
3. I will verify and accurately label all specimen containers prior to leaving the collection site.
4. Safe Patient Handling Equipment will be used in all situations where the patient is unable to safely transfer, position, or ambulate independently.
5. For all Nursing Personnel: I will apply appropriate fall precautions for all patients whose Fall Risk Assessment indicates elevated fall risk.
6. For all Personnel participating in invasive procedures: I will perform surgical counts in accordance with policy on any procedure in which a foreign body could be retained.
7. For all Personnel participating in invasive procedures: I will participate in a time out before every procedure begins, using validation of correct patient, correct procedure, correct site by the procedural team which should include at a minimum the physician, circulator/nurse, and anesthesia care provider.

**Conway Medical Center Behavior Based Expectations/Error Prevention Techniques Employees**

| 1. Communicate Effectively | 1. Identify Self, Department & Purpose  
|                           | 2. Use Repeat-Backs and Read-Backs with Clarifying Questions  
|                           | 3. Use SBAR (Situation, Background, Assessment, Request/Recommendation) for Reports and Handoffs  |
| 2. Take “Time-Out” for Detail | 1. Use S.T.A.R. (Stop, Think, Act, Review)  |
|                       | 2. Practice Peer Checking and Peer Coaching using ARC  
|                       | 3. STOP when Unsure & seek clarification and assistance  
|                       | 4. Raise the Red Flag |

My Personal Safety Commitment:

1. I have received training and education on Red Rules, Behavior Based Expectations, and Error Prevention techniques.
2. I will comply exactly and at all times with the Red Rules.
3. If compliance with a Red Rule is not possible, I shall STOP any action until any uncertainty can be resolved.
4. I will employ error prevention techniques as a part of my daily work.

I understand that compliance problems with Red Rules shall be managed in accordance with CMC’s Safety Responsibility Policy. No less than a written reprimand shall be given for Red Rule non-compliance.

Signature  ID Number  Date
Conway Medical Center
Conway South Carolina

Student Responsibility Notice

__________________________________________
(“Student”) will be participating in an educational experience at Conway Medical Center (CMC), pursuant to an affiliation agreement between Hospital and ___________________________ (“School”).

- The Student will adhere to the policies, procedures, rules, and regulations of CMC while assigned here and is required to wear attire acceptable for the clinical setting.

- The Student understands that it is the Student’s responsibility to ensure that he/she has adequate health insurance coverage. CMC does not provide health insurance to students. It is the student’s responsibility to inform CMC of any communicable disease he/she has and will not return to clinical until cleared through Infection Control.

- The Student understands that CMC does not provide liability insurance for students. The Student must be covered by his/her own professional liability insurance or that of the School’s. The limits of liability should minimally be $1,000,000 per incident and $3,000,000 per aggregate.

- The Student understands that CMC does not provide Worker’s Compensation coverage for students.

- CMC will make available to the student emergency services for injury and illness incurred as a direct result of the student’s clinical learning experiences. Charges incident to such services shall be directed to the student, or designated third party payment. CMC will inform the School and, if appropriate, the student’s parents of any emergency medical situation arising regarding the student’s health.

- The student certifies that School has provided him/her with appropriate information on Confidentiality, HIPAA, Infection Control, Fire, MRI and Patient Safety, Interpreters, Special Needs Patients and Environment of Care issues training prior to this clinical assignment. Training has also been provided on the Code of Conduct. Violations can result in the inability to complete the clinical experience at Conway Medical Center. The student understands that all policies can be found on the intranet.

__________________________________________  ______________________________________
Student  Witness

__________________________________________
Date
EXHIBIT A

STATEMENT OF CONFIDENTIALITY

As a participant in clinical rotations at Myrtle Beach Rehabilitation Hospital, LLC (the “Hospital”), I hereby acknowledge my responsibility to keep all patient and business information of the Hospital and Encompass Health Corporation (formerly named HealthSouth Corporation) confidential, in accordance with federal and state laws and regulations and this Agreement made by and between the Hospital and Horry-Georgetown Technical College (the “School”). Furthermore, I agree, under penalty of law, not to disclose: (i) specific information regarding any patient to any person or persons, except to authorized clinical staff and associated personnel as necessary to perform my clinical rotation duties; and (ii) any confidential business information of the Hospital and Encompass Health Corporation to any third party. This Statement of Confidentiality shall continue in effect after my clinical rotation at the Hospital has expired or terminated.

Dated this _____ day of _________________________, 20____.

______________________________
Name of Student (Print)

______________________________
Student Signature
EXHIBIT B

DRUG AND ALCOHOL POLICY ACKNOWLEDGEMENT FORM

(CONFIDENTIAL)

By signing below, I hereby acknowledge that I have received a copy of Myrtle Beach Rehabilitation Hospital, LLC’s (“Hospital”) Drug and Alcohol Policy and agree that I will read and abide by the policy.

I understand that situations may occur in which I will be required to take a drug or alcohol test or submit to a search of my person or possessions in accordance with Hospital policy. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a drug or alcohol test; (ii) by refusing to allow a search; (iii) if a drug or alcohol test proves positive; or (iv) if a search discloses possession of a prohibited item, such as a weapon.

I further understand if I am involved in a work-related accident, I may be required to submit to a blood or urine test. I also understand that I may be withdrawn from participation in my clinical rotation at the Hospital: (i) by refusing to take a blood or urine test; or (ii) if such blood or urine test proves positive.

I also understand that upon my request I will be provided a list of all drugs / substances for which tests will be conducted.

I further understand that adherence to Hospital’s Drug and Alcohol Policy is a condition of clinical rotation for all students and hereby consent to and accept such policy as a condition of my rotation.

Name of Student (Print)       Date

Student Signature

Exhibit B
EXHIBIT C

RELEASE STATEMENT CERTIFICATION

I hereby authorize Myrtle Beach Rehabilitation Hospital, LLC (“Hospital”) and/or its agents to make an independent investigation of my background for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualification for employment or participation in clinical rotations, and to conduct pre-employment or other employment related inquiries after I am hired or selected to participate in a clinical rotation at Hospital (to the extent allowed by law), if applicable. This investigation may access records maintained by both public and private organizations. Information requested may include, but is not limited to:

- Professional and personal references
- Credit history (Consumer Reports)
- Motor vehicle records
- Past and current employment
- Education
- Professional credentials
- Criminal and police records
- Public records
- Urine or blood tests to determine drug or alcohol use.

I authorize any individuals or entities contacted during this investigation to give you any and all pertinent information they may have, personal or otherwise, and release all parties from any and all liabilities, claims or law suits in regard to the information obtained.

I understand that the complete and final results of Hospital’s investigation of my background may not be available to Hospital before my employment or clinical rotation at the Hospital commences. I also understand that the results of Hospital’s investigation into my background may affect my employability, my continuing employability or eligibility to participate in a clinical rotation within the Hospital.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signed: ___________________________ Date: ___________________________

(Student)

PLEASE PRINT THE FOLLOWING INFORMATION. FILL IN ALL BLANKS COMPLETELY:

Last Name: ___________________________________________________________________

Name: First Name: Middle Name: ___________________________________________________________________

Other names you have used in the past 5 years. (Maiden name, nickname, alias, etc.): ___________________________________________________________________

Present Address: ___________________________________________________________________

Previous: ___________________________________________________________________

Provide the following information on places you have worked or lived during the past five years:

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

Driver’s License No.: ___________________________ State of License: __________ *Date of Birth: ___________________________

Social Security Number: ___________________________ Applying For: ___________________________
If an investigative consumer report is pulled on me for employment purposes, I wish to receive a copy of the report from TransUnion Birmingham Division.

*Date of birth is used only for purposes of record identification when requesting the above mentioned reports.*

---

**FOR HOSPITAL USE ONLY**

**The following information must be completed by the Hospital in order to process this request. Please PRINT clearly.**

<table>
<thead>
<tr>
<th>Hospital Name:</th>
<th>Myrtle Beach Rehabilitation Hospital, LLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Number:</td>
<td></td>
</tr>
</tbody>
</table>

Hospital Number: Secured Fax Number: 

Requested By: 

E-Mail Address: 

Title: Clinical Rotation Student □ nursing, □ therapy, □ pharmacy or □ other clinical care and treatment fields

Please indicate the type of background check requested:

- **Credit**: Required for designated positions prior to offer of employment. Result: ______ Date: ______ Source: ______

- **Criminal**: Required for all positions immediately upon candidate’s acceptance of employment offer. Result: ______ Date: ______ Source: ______

- **FACIS (OIG/GSA)**: Screen through Certiphi Screening Inc. Previously performed through Cornerstone. Please see the Compliance Homepage for instructions. Result: ______ Date: ______

Hospital Use ONLY: Fax form to: 205-802-7896; To obtain results call: 1-800-417-4669 or check your e-mail address.
EXHIBIT D

HIPAA STUDENT TRAINING / ORIENTATION

Confidentiality and Privacy mean that the patients have the right to control who will see their protected health information. With the enactment of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), a patient’s right to have his/her health information kept private, secure and confidential became more than just an ethical obligation of healthcare providers; it became a federal law.

Protected Health Information (“PHI”) includes patient identity, address, age, social security number and any other personal information that patients are asked to provide. In addition, protected health information includes why a person is sick or in the Hospital, what treatments and medications he/she may receive, and other observations about his/her condition or past health conditions.

Healthcare providers use information about patients to determine what services they should receive. Ask yourself before looking at any protected health information:

- Do I need this in order to perform clinical rotation duties and provide quality care?
- What is the least amount of information I need to perform clinical rotation duties?

Depending on your task, if you do not need to know confidential patient information, then you should not have access to it.

Ways to protect a patient’s privacy include:

- Keep discussions about patient care private if reasonably possible by closing doors, pulling curtains and conducting discussions so that others cannot overhear.
- Keep medical records locked and out of public areas.
- If you find that you are overhearing someone else discuss patient information, let them know they can be overheard, and politely remind the individual of the Hospital’s privacy policies.
- Do not release any patient information, unless your supervisor has obtained a written authorization from the patient.
- Do not leave messages on answering machines regarding a patient’s condition or test results.
- If you should need to copy medical records to complete an assignment, ask your supervisor for permission before making copies. Redact the patient’s personal identifiers (i.e., name, date of birth, address, medical record number, insurance information and social security number, if captured) prior to taking the record out of the hospital. **Return all copies to the hospital and shred.**
- If there are persistent problems regarding breaches of confidentiality or you have any questions, notify of contact your clinical rotation supervisor at the Hospital.
- As a student participating in a clinical rotation at the Hospital, I recognize the patients’ right to privacy and agree to abide by the Patient’s Bill of Rights as posted within the Hospital.
- Additionally, I agree that information relating to a patient’s physical and/or emotional status will not be released or discussed except as needed for the care of that patient.

I also understand that breaking HIPAA’s rules and regulations can mean either a civil or criminal sanction (penalty).

My signature below indicates that I have read and understood the above information, and will abide by the policies and procedures of the Hospital.

<table>
<thead>
<tr>
<th>Date</th>
<th>Student Signature</th>
<th>Student Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Employee Signature</th>
<th>Employee Name</th>
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</tbody>
</table>

Exhibit D

(CW2326751; ID 159774)
Name: _____________________________

I, ______________________________, have received and reviewed the orientation packet to Tidelands Health Rehabilitation Hospital, an Affiliate of Encompass Health, and understand that I must complete additional on-site orientation prior to providing services.

There will be an opportunity to ask any additional questions during on-site orientation.

_____________________________   __________________
Signature of contractor          Date

_____________________________
CEO

_____________________________
HR Director
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 #: ___________
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
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:

<table>
<thead>
<tr>
<th>Hospital or Nursing Home</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conway Manor</td>
<td></td>
<td></td>
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<tr>
<td>Conway Medical Center</td>
<td></td>
<td></td>
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<tr>
<td>Georgetown Healthcare and Rehab</td>
<td></td>
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<tr>
<td>Grand Strand Regional Medical Center</td>
<td></td>
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<tr>
<td>Kingston Nursing Home</td>
<td></td>
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<tr>
<td>Lighthouse Care Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McLeod (Seacoast, Loris, Florence, Etc.)</td>
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<td></td>
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<tr>
<td>National Healthcare (NHC Garden City)</td>
<td></td>
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<tr>
<td>The Lakes at Litchfield</td>
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<td></td>
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<tr>
<td>Tidelands (Waccamaw, Georgetown, Etc.)</td>
<td></td>
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<tr>
<td>Other (Please List):</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Hospital or Nursing Home</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Other (Please List):</td>
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</table>

HGTC INTERNAL USE ONLY:

HGTC (Faculty Name): ___________________________  Date: ___________________________
Confirmed With (Clinical Partner Personnel): ___________________________
Comments: ___________________________________________________________________________
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!

**STUDENT BACKGROUND CHECK, DRUG SCREENING & IMMUNIZATION/HEALTH INFORMATION PACKET**

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 1st Clinical / Field Class</th>
<th>Package Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Hygiene <em>see note under Fees</em></td>
<td>1st and 4th DHG 151</td>
<td>HG37 (cost $112.00)</td>
</tr>
<tr>
<td>Diagnostic Medical Sonography <em>see note under Fees</em></td>
<td>1st and 4th DMS 164</td>
<td>HG13 (cost $112.00)</td>
</tr>
<tr>
<td>Emergency Medical Technician <em>see note under Fees</em></td>
<td>2nd EMS 109</td>
<td>HG01 (cost $112.00)</td>
</tr>
<tr>
<td>Expanded Duty Dental Assisting <em>see note under Fees</em></td>
<td>1st DAT 154</td>
<td>HG51 (cost $112.00)</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>2nd MTH 135</td>
<td>HG89 (cost $112.00)</td>
</tr>
<tr>
<td>Nursing <em>see note under Fees</em></td>
<td>Every Semester 101 / 201</td>
<td>HG08 (cost $112.00)</td>
</tr>
<tr>
<td>Paramedic <em>see note under Fees</em></td>
<td>1st EMS 223</td>
<td>HG01 (cost $112.00)</td>
</tr>
<tr>
<td>Patient Care Technician <em>see note under Fees</em></td>
<td>2nd AHS 163</td>
<td>HL13 (cost $112.00)</td>
</tr>
<tr>
<td>Phlebotomy <em>see note under Fees</em></td>
<td>1st AHS 167</td>
<td>HG73 (cost $112.00)</td>
</tr>
<tr>
<td>Physical Therapist Assistant <em>see note under Fees</em></td>
<td>Every Semester PTH 234</td>
<td>HG70 (cost $112.00)</td>
</tr>
<tr>
<td>Practical Nursing <em>see note under Fees</em></td>
<td>Every Semester PNR 110</td>
<td>HG18 (cost $112.00)</td>
</tr>
</tbody>
</table>

**MAJOR**

<table>
<thead>
<tr>
<th>Package Code</th>
<th>Semester 1st Clinical / Field Class</th>
<th>MAJOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HG02</td>
<td>1st, 3rd and 5th RAD 153</td>
<td>Radiologic Technology <em>see note under Fees</em></td>
</tr>
<tr>
<td>HG02</td>
<td>1st and 4th RES 152</td>
<td>Respiratory Care <em>see note under Fees</em></td>
</tr>
<tr>
<td>HG05</td>
<td>1st and 2nd SUR 101</td>
<td>Surgical Technology <em>see note under Fees</em></td>
</tr>
</tbody>
</table>

Criminal Background Check and/or Urine Drug Screen REQUIRED as indicated below:

<table>
<thead>
<tr>
<th>MAJOR</th>
<th>Package Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sports Tourism</td>
<td>HH78 (cost $112.00)</td>
</tr>
<tr>
<td>Criminal Justice Background Check ONLY</td>
<td>IMMEDIATELY upon admission HG63BG (cost $75.00)</td>
</tr>
<tr>
<td>Early Care and Education/Early Childhood Development Background Check ONLY <em>see note below</em></td>
<td>1st Semester HG48BG (cost $75.00)</td>
</tr>
<tr>
<td>Cosmetology</td>
<td>IMMEDIATELY upon admission HG95 (cost $112.00)</td>
</tr>
<tr>
<td>Esthetics</td>
<td>IMMEDIATELY upon admission HG04 (cost $112.00)</td>
</tr>
<tr>
<td>Machine Tool Operations and Technology Drug Screen ONLY</td>
<td>30-Days Prior to Fall and/or Spring Semester HS73DT (cost $37.00)</td>
</tr>
<tr>
<td>Welding Drug Screen ONLY</td>
<td>30-Days Prior to Fall and/or Spring Semester HS53DT (cost $37.00)</td>
</tr>
</tbody>
</table>

*IF YOU ARE REGISTERING FOR ECD 101 ONLY WITH NO OTHER COURSES IN THE ECD MAJOR, NO BACKGROUND CHECK IS REQUIRED*

**PACKAGE CODE CHART**

- Radiologic Technology *see note under Fees*
- Respiratory Care *see note under Fees*
- Surgical Technology *see note under Fees*
- Dental Hygiene *see note under Fees*
- Diagnostic Medical Sonography *see note under Fees*
- Emergency Medical Technician *see note under Fees*
- Expanded Duty Dental Assisting *see note under Fees*
- Massage Therapy
- Nursing *see note under Fees*
- Paramedic *see note under Fees*
- Patient Care Technician *see note under Fees*
- Phlebotomy *see note under Fees*
- Physical Therapist Assistant *see note under Fees*
- Practical Nursing *see note under Fees*
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 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.
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.

<table>
<thead>
<tr>
<th>Student’s Name (Print)</th>
<th>Student’s Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student ID Number (H#)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program of Study (Major)</th>
<th>HGTC Staff</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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.

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**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>Location</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONWAY LAB</strong></td>
<td>812 Farrar Dr. Suite A</td>
<td>843-347-8480</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MYRTLE BEACH LAB</strong></td>
<td>1021 Cipriana Dr. Suite 260</td>
<td>843-497-6726</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MURRELLS INLET LAB</strong></td>
<td>4017 Hwy 17 S, Suite 202</td>
<td>843-651-3003</td>
</tr>
</tbody>
</table>

---

**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**
     - Admission Office – Attention: Dana Mason Gasque
   - **Grand Strand**
     - Speir Building Room 1282-O – Attention: Dana Mason Gasque
   - **Georgetown**
     - 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

3. **Email:**
   - Dana.Gasque@hgtc.edu (please make sure all scanned documents are legible)

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

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Revised 08/12/2019 \ 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>Palmetto Express Clinic 843-750-0324</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>Sliding Scale</td>
<td></td>
<td></td>
<td>$50.00</td>
<td>$50.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella Titer</td>
<td>$40.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$30.00</td>
<td>$50.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B Titer</td>
<td></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 <em>QFT Gold Tests are Acceptable</em></td>
<td>$25.00</td>
<td>$64.00</td>
<td>$34.00</td>
<td>$40.00</td>
<td>$20.00</td>
<td>$42.00</td>
<td>$35.00</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>$40.00</td>
<td></td>
<td></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>$125.00</td>
<td></td>
<td></td>
<td></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>$96.00</td>
<td>$75.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella Vaccine x1</td>
<td>$168.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$186.00</td>
<td></td>
<td></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>$70.00</td>
<td>$92.00</td>
<td>$65.00</td>
<td></td>
</tr>
<tr>
<td>Flu</td>
<td>$28.00</td>
<td>$28.00</td>
<td>$32.00</td>
<td>$29.00</td>
<td>$35.00</td>
<td>$20.00</td>
<td>$30.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam</td>
<td>$75.00</td>
<td>$79.00</td>
<td>$50.00</td>
<td></td>
<td></td>
<td>$100.00</td>
<td>$50.00</td>
<td></td>
<td>$45.00</td>
</tr>
</tbody>
</table>

Revised 10/01/2019 \[www.hgtc.edu\]
### VACCINE ALLERGY/WAIVER FORM

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

---

Signature: __________________________ Title (MD, NP, PA)

Signature: __________________________ Title (MD, NP, PA)