HORRY GEORGETOWN TECHNICAL COLLEGE

HGTC Health Science
Clinical Requirements

for

Patient Care Medical Assistant

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STUDENT NAME: _____ **PROGRAM:** Patient Care Medical Assistant

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☐		**Physical Waiver** - *ONLY if there are no medical changes	1 Year		
☐	4.	**Initial Tuberculin Skin Test** PPD 2 Step **OR** QFT Gold Blood Assay PPD 2 Step (4 visits) Step 1 Administered ☐ Step 1 Read Result ☐- ☐+ Step 2 Administered ☐ Step 2 Read Result ☐- ☐+ **OR** QFT Gold Blood Assay Lab Results ☐- ☐+	Initial Step 1 Read: Step 2 Read: QFT Date:		NA
☐		**Annual Tuberculin Skin Test** PPD 1 Step **OR** QFT Gold Blood Assay PPD 1 step (2 visits) Step 1 Administered ☐ Step 1 Read ☐- ☐+ **OR** QFT Gold Blood Assay Lab Results ☐- ☐+	1 Year Step 1 Read: QFT Date:		
☐		IF PPD is Positive, Chest x-ray (CXR) is required - Need Physician documentation Chest x-ray result (CXR) ☐- ☐+	2 Years CXR Date:		
☐		IF PPD is Positive, complete the Symptom Assessment form	Every Semester PPD-SA Date:		
☐	5.	**Flu Vaccine -** TIV or LIAV Vaccine x 1 Requirement may change based on prevalent strains	Flu Season		
☐	6.	**TDAP (ADULT) -** Immunization x 1	10 Years		
☐	7.	**Hepatitis B** Prior Hep B vacs can be used (i.e. Military, childhood records) ☐ Declination Form **OR** TITER Result: ☐- ☐+ **OR** ☐ 3 Series Immunizations Dose 1= now Dose 2=1 month after dose 1 Dose 3=5 months after dose 2	Initial Dose 1: Dose 2: Dose 3:		NA
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		IF MMR Titers show NON-IMMUNE Combination Vaccine x 2 Required (can be given 28 days apart) MMR #1 Date: *Prior MMR vaccination can be used as MMR #1; booster for #2 required MMR #2 Date:	If MMR titers positive, you may skip		
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		IF Varicella Titer show NON-IMMUNE Vaccine x 2 Required (can be given 28 days apart) VAR #1 Date: *Prior VAR vaccination can be used as VAR #1; booster for #2 required VAR #2 Date:	If VAR titer positive, you may skip		
☐	10.	**Certificate of Liability - Insurance (remit the certificate)** Policy Coverage: Up to $1,000,000 each claim professional liability coverage Up to $3,000,000 aggregate professional liability coverage	1 Year		
☐	12.	**Castle Branch Affidavit – submit to Admissions**	Initial		

IMPORTANT NOTES

- Any item that will expire mid semester must be completed before the semester begins. Example, your CPR Certificate expires in March, you must renew your certificate before classes start in January.
- You may bring your documents to Clinical Admissions Coordinator's office located in the Speir Building or email them to hgtc-clinical@hgtc.edu . If you email, all documents must be one sided, legible and submitted as a pdf file. DO NOT submit documents into the body of an email. DO NOT submit documents as images. Scan them. There are apps available to download on your phone to scan documents. Please put your program name in the Subject line of EVERY email, even if it is a simple question. Do not submit one document at the time. Scan all documents into one pdf attachment.
- **CPR Certification must be BLS HealthCare Provider through AHA or ARC ONLY.**
- One year from the date of your physical, a **physical waiver** must be submitted annually if there has been no change in your health status.
- **Initial PPD 2 Step is 4 office visits**: **1st** – administered **2nd** – read 48-72 hrs. after 1st visit, **3rd** – administered again 7-21 days later, **4th** – read 48-72 hrs. after 3rd visit.
- We recommend for Step 2 to be administered 7 days after Step 1; however, the max time frame between Step 1 and Step 2 is 21 days.
- You must have an **annual PPD or QFT**. Do not let time lapse or you will need to complete the PPD 2 step again. Example: If your PPD 2 Step was completed May 1st, your annual PPD 1 Step MUST be completed no later than May 1st.
- **If your PPD is positive**, you must have a chest x-ray immediately following the result. A chest x-ray is then required every 2 years.
- **If your PPD is positive**, a PPD symptom assessment form must be completed every semester.
- **Hepatitis B** - There are 3 options to choose from:
  1- Receive the 3 dose series. You receive the 2nd dose 1 month after the 1st. The 3rd dose is received 5 months after the 2nd. Please check the first 2 boxes of the Hep B Waiver (page 16), sign, date and remit along with Dose # 1. *If you received 3 doses in the past, we will accept those as your 3 doses.
  2- You may have a titer to check your immunity. If negative/non-reactive (non-immune), you will need to sign the waiver or begin the 3 series dose. You may use 2 Hep B vaccines from a prior record (childhood, military, etc.) and then just receive a booster to count as the 3rd one.
  3- If you opt out, please see the Hepatitis Declination Waiver on page 16. Check the first box, sign & date.
- **MMR and Varicella titers are required**. DO NOT go for vaccinations until you have your titers completed. If positive (immune), no MMR or Varicella booster is required. If negative (non-immune) for the Mumps, Measles or Varicella, 2 boosters are required. Only 1 booster is needed for Rubella. For the 2 boosters, a prior vaccination (childhood, military, etc.) can count as the 1st one and you will only need to receive the one booster. You will need to remit a copy of your immunization record.
- **Liability insurance** – Need the Certificate of Liability, not a copy of the application.

careLearning

South Carolina Passport Project

You will use Care Learning 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, use your school issued email address. 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 modules must be completed yearly. 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.

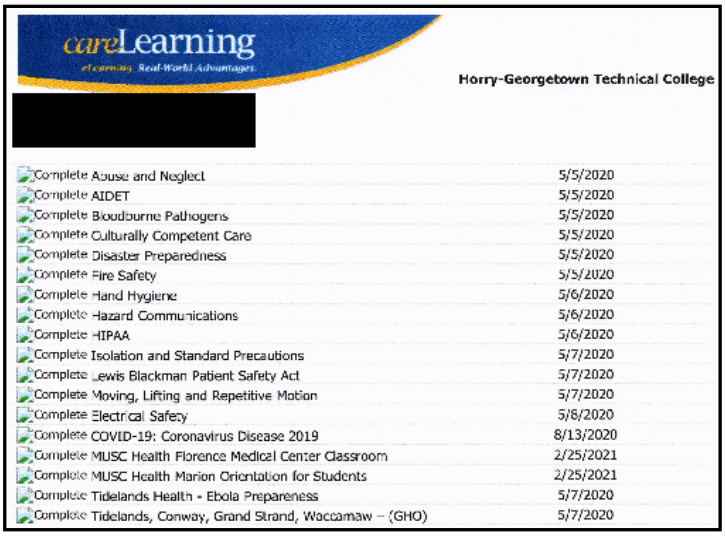
Below are the 18 modules that need to be completed for Horry-Georgetown Technical College:

Abuse & Neglect	**HIPAA**
AIDET	**Isolation ad Standard Precautions**
Bloodborne Pathogens	**Lewis Blackman Patient Safety Act**
COVID-19: Coronavirus Disease 2019	**Moving, Lifting and Repetitive Motion**
Culturally Competent Care	** **YOU WILL NEED TO MANUALLY ADD:**
Disaster Preparedness	• **MUSC Health Florence Medical Center Classroom**
Electrical Safety	• **MUSC Health Marion Orientation for Students**
Fire Safety	• **Tidelands Health – Ebola Preparedness**
Hand Hygiene	• **Tidelands, Conway, Grand Strand, Waccamaw – (GHO)**
Hazard Communications	

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

5. You are required to remit a copy of your completed Transcript to HGTC-Clinical@hgtc.edu .

Example of completed transcript


careLearning
eLearning. Real-World Advantages.

Horry-Georgetown Technical College

[redacted]

Complete Abuse and Neglect	5/5/2020
Complete AIDET	5/5/2020
Complete Bloodborne Pathogens	5/5/2020
Complete Culturally Competent Care	5/5/2020
Complete Disaster Preparedness	5/5/2020
Complete Fire Safety	5/5/2020
Complete Hand Hygiene	5/6/2020
Complete Hazard Communications	5/6/2020
Complete HIPAA	5/6/2020
Complete Isolation and Standard Precautions	5/7/2020
Complete Lewis Blackman Patient Safety Act	5/7/2020
Complete Moving, Lifting and Repetitive Motion	5/7/2020
Complete Electrical Safety	5/8/2020
Complete COVID-19: Coronavirus Disease 2019	8/13/2020
Complete MUSC Health Florence Medical Center Classroom	2/25/2021
Complete MUSC Health Marion Orientation for Students	2/25/2021
Complete Tidelands Health - Ebola Preparedness	5/7/2020
Complete Tidelands, Conway, Grand Strand, Waccamaw – (GHO)	5/7/2020

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

CPR: BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS FORM

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

CPR Completion Date:	Certifying Agency:	Instructor's Initials	Expiration Date:
	☐ AHA ☐ ARC		

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: Take this form with you to your CPR class for your instructor to complete. This form serves as temporary documentation for CPR. The student is responsible for remitting a copy of the BLS Card to the Clinical Admissions Specialist. Cards typically take 30 days to receive. If it has been more than 30 days, the student is responsible for following up with their BLS Instructor regarding the BLS Card.

CPR/BLS Vendors - Prices and Information Subject to Change

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

Horry-Georgetown Technical College - Continuing Education – Betty Turner, Program Manager
Cost: $105.00 (Materials Included)
743 Hemlock Avenue, Bldg. 600 Room 627, Myrtle Beach, SC 29577 - 843-477-2020 or 843-477-2079
Betty.Turner@hgtc.edu
Dates of CPR classes can be found at www.hgtc.edu/jobtraining.

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

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 hgtc-clinical@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

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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

SECTION I (to be completed by student)

Name: _____
(Last) (First) (Middle)

Other Name(s) Student Known As: _____ Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: _____
(Home) (Cell) (Work)

Past Medical History: **ALLERGIES:** _____

Have you had? CHECK Yes or NO	Yes	No	**Have you had? CHECK Yes or NO**	Yes	No
Rubeola			Stomach/Intestinal Abnormality		
Rubella			Arthritis		
Mumps			Asthma		
Chicken pox (MD documented)			Hay fever		
Infectious Mono			Color blindness		
Positive TB Skin Test			Recurrent headaches		
Recurrent Herpes Viruses			Back problems		
Sexually Transmitted Disease			Organ transplant		
Heart disease			Insomnia		
Heart murmurs			Frequent Anxiety		
Mitral Valve Prolapsed			Frequent Depression		
High Blood Pressure			Worry or Nervousness		
Rheumatic fever			Hepatitis (specify: A,B,C,D,E)		
Diabetes			Epilepsy/Convulsions		
Kidney/Bladder Abnormality			Other (explain below):		

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

If you checked "Yes" to any past medical history on the previous physical page , 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/ _____
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)

System	**Yes**	**No**	System	**Yes**	**No**
Eyes			Musculoskeletal		
Ears			Metabolic/Endocrine		
Nose, throat			Genitourinary		
Neurological			Skin		
Respiratory			Immunological		
Cardiovascular (including murmurs)			Psychiatric		
Gastrointestinal			Other (please explain)		

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).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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.

PPD	Date/Time Given	Injection Site	Lot # & Manufacturer	Expiration	Result	Induration	Date/Time Read	Initials
Step 1 (2 visits)					☐ Negative ☐ Positive	_____**mm**		
Step 2 (2 visits)					☐ Negative ☐ Positive	_____**mm**		
QFT Gold Blood Assay		**If you elect a QFT instead of the PPDs, you must remit a copy of the lab results.**			☐ Negative ☐ Positive			

- 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. ***There is a max time frame of 21 days between Step 1 and Step 2.**
- Annual 1 Step PPD must be completed before the prior one expires.
- 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.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

Tetanus, Diphtheria, Pertussis (TDAP) Form

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
Booster						

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.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

HEPATITIS B FORM

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						
3.						

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.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

MANDATORY HEPATITIS B VACCINE/DECLINATION

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

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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:
    - If all 3 MMR or Measles or Mumps are **NEGATIVE** or **EQUIVOCAL**: Two (2) doses of MMR are required.
    - If Rubella is **NEGATIVE** or **EQUIVOCAL**: One (1) dose of MMR is required.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
4.						
5.						

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.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

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.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
6.						
7.						

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)

Dental Hygiene (DHG)

Diagnostic Medical Sonography (DMS)

EMT/Paramedic (EMS)

Licensed Practical Nurse (LPN/PNR)

Nursing Assistant (AHS 163)

Phlebotomy (AHS 167)

Physical Therapy (PTH)

Radiology Tech (RAD)

Registered Nurse (NUR)

Respiratory Care (RES)

Surgical Tech (SUR)

Visit www.hpso.com (*)

Select “Get a Quote – Apply Now”

Select “Individual” and “Continue”

Follow the prompts as a “Student”

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

You will receive an email confirming your application was submitted.

Within 24-48 hours, you will receive an email containing your actual Policy. You are required to remit a copy of the Certificate of Liability to hgtc-clinical@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.

HORRY GEORGETOWN TECHNICAL COLLEGE

Additional Admission/Placement Requirements Affidavit

(Required at the Time of Application to an Applicable Program of Study)

ITEM #1

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

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

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

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

Certification of Understanding

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

Student's Name (Print)	**Student's Signature**	**Date Signed**
Student ID Number (H#)	**_____/_____/_____ Date of Birth**	
Program of Study (Major)	**HGTC Staff**	**Date Signed**

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

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:

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

PACKAGE CODE CHART

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

MAJOR	*Semester*	*1st Clinical / Field Class*	*Package Code*
Dental Hygiene *see note under Fees*	1st and 4th	DHG 151	**HG37** (cost $112.00)
Diagnostic Medical Sonography *see note under Fees*	1st and 4th	DMS 164	**HG13** (cost $112.00)
Emergency Medical Technician *see note under Fees*	2nd	EMS 109	**HG01** (cost $112.00)
Expanded Duty Dental Assisting *see note under Fees*	1st	DAT 154	**HG51** (cost $112.00)
Massage Therapy	IMMEDIATELY upon admission		**HG89** (cost $112.00)
Nursing *see note under Fees*	Every Semester	NUR 101 / 201	**HG08** (cost $112.00)
Paramedic *see note under Fees*	1st	EMS 223	**HG01** (cost $112.00)
Patient Care Technician *see note under Fees*	2nd	AHS 163	**HL13** (cost $112.00)
Phlebotomy *see note under Fees*	1st	AHS 167	**HG73** (cost $112.00)
Physical Therapist Assistant *see note under Fees*	Every Semester	PTH 234	**HG70** (cost $112.00)

MAJOR	*Semester*	*1st Clinical / Field Class*	*Package Code*
Practical Nursing *see note under Fees*	Every Semester	PNR 110	**HG18** (cost $112.00)
Radiologic Technology *see note under Fees*	1st, 3rd and 5th	RAD 153	**HG02** (cost $112.00)
Respiratory Care *see note under Fees*	1st and 4th	RES 152	**HN82** (cost $112.00)
Surgical Technology *see note under Fees*	1st and 2nd	SUR 101	**HG05** (cost $112.00)

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

MAJOR		*Package Code*
Sports Tourism	2nd Semester	**HH78** (cost $112.00)
Criminal Justice ***Background Check ONLY***	IMMEDIATELY upon admission	**HG63BG** (cost $75.00)
Police Pre-Academy	IMMEDIATELY upon admission	**HZ71** (cost $112.00)
Early Care and Education/Early Childhood Development ***Background Check ONLY*** ****See note below****	1st Semester	**HG48BG** (cost $75.00)
Cosmetology	IMMEDIATELY upon admission	**HG95** (cost $112.00)
Esthetics	IMMEDIATELY upon admission	**HG04** (cost $112.00)

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

FEES: There will be a non-refundable $75 criminal background check fee and $37 urine drug-screening fee (in addition to any HGTC application fee). **All Nursing/Allied Health/Limited Access Students: *A criminal background check and urine drug screen must be completed no greater than 30 days prior to the start of clinical rotation each semester or upon request by the clinical site.*** All fees are paid to a third-party provider and, therefore, cannot be "billed" to the student.

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

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

The student MUST:

- **Sign an Additional Admission/Placement Requirements Affidavit (Item #1). Return to admission office at one of the three campuses.**
- **Go online to www.castlebranch.com 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.

ITEM #2

Student Instruction Sheet

Criminal Background Check/Drug Screening/Immunization & Health Records

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

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

STEP 1: Create Account and Begin the Process

1) Go to www.castlebranch.com
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**:

CONWAY LAB	MYRTLE BEACH LAB	MURRELLS INLET LAB
812 Farrar Dr. Suite A	1021 Cipriana Dr. Suite 260	4017 Hwy 17 S, Suite 202
Phone: 843-347-8480	Phone: 843-497-6726	Phone: 843-651-3003
Hours: Monday-Friday*	Hours: Monday-Friday*	Hours: Monday-Friday*
7:30am-12:30pm & 2:00pm-3:30pm*	7:30am-12:30pm & 2:00pm-3:30pm*	8:30am-11:30am & 1:00pm-3:30pm*

* Hours of operation are subject to change. Please visit www.labcorp.com to find a location near you!

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

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

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

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

1. **Drop off locations:**
   - **Conway** – **Admissions Office – Attention: Clinical Admissions Coordinator**
   - **Grand Strand** – **Speir Building – Attention: Clinical Admissions Coordinator**
   - **Georgetown** – **Admissions Office – Attention: Clinical Admissions Coordinator**
2. **Mail:**
   Horry-Georgetown Technical College
   Clinical Admissions Coordinator
   3501 Pampas Drive
   Myrtle Beach, SC 29577
3. **Email:** HGTC-Clinical@hgtc.edu *** Please make sure all scanned documents are legible ***

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

***Questions or concerns please email HGTC-Clinical@hgtc.edu.**

Revised 04/12/2021 \ www.hgtc.edu

Immunization Cost Estimates for Students
WITHOUT Health Insurance Coverage
Some of these ARE covered under most health insurance plans

DISCLAIMER: This information is to be used as a guide only, as it is subject to change. 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 and is unable to recommend any specific provider. **IF THESE PROVIDERS DON'T WORK FOR YOU, YOU MAY USE YOUR OWN PROVIDER.**

Immunization	Beach Family & Urgent Care 843-626-2273	Carolina Health Pharmacy 843-215-8200	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	Little River Medical Center (5 different locations) 843-663-8000	Med Plus 843-357-2443	Palmetto Express Clinic 843-750-0324	Southern Urgent Care 843-357-4357
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	$25.00 (PPD) $132.00 (QFT)	NA	$74.00	$34.00 $60.00 (QFT)	Sliding Scale	$25.00	$20.00 (PPD) $100 (QFT)	$35.00 (PPD) $110.00 (QFT)
Chest X-Ray with Positive PPD	$53.00	NA	NA	$100.00	Sliding Scale	$50.00	NA	$100.00
MMR Titer	$90.00	NA	$99 - $139	$80 each +$51 stick fee	Sliding Scale	NA	$60.00	$50.00
Varicella Titer	$40.00	NA	$99 - $139	$85.00	Sliding Scale	NA	$30.00	$50.00
Hep B Titer	$32.00	NA	$99 - $139	$75.00	Sliding Scale	NA	$30.00	$30.00
MMR Vaccine x 1	NA	$115.00	$135.00	NA	Sliding Scale	$90.00	NA	NA
Hep B Vaccine x 1	NA	$92.00	$145.00	$156.00	Sliding Scale	$90.00	NA	NA
Varicella Vaccine x1	NA	$168.00	$140.00	NA	Sliding Scale	$125.00	NA	NA
TDAP (Adacel) Vaccine	NA	$64.00	$95.00	$71.00	Sliding Scale	$70.00	NA	$65.00
Flu	$28.00	$28.00	$50.00	$29.00	Sliding Scale	$25.00	$30.00	$35.00
Physical Exam	$75.00	NA	$89.00	$50.00	Sliding Scale	$100.00	$50.00	$45.00

For students who meet certain income guidelines, many of these services are provided at low or no cost through **the SC Health Departments**. Call (855) 472-3432 to make an appointment at any of these locations.

- Myrtle Beach Health Dept, 21st Ave, Myrtle Beach
- Conway Health Dept., Industrial Park Road, Conway
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River
- Georgetown County Public Health Department, Lafayette Cir, Georgetown

HORRY GEORGETOWN TECHNICAL COLLEGE Health Science Division – Student Health Record	Student Name: _____ Student H#_____ Program: _____

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

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

SYMPTOM ASSESSMENT FORM
(Required Every Semester)

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

Date: _____ Date of Positive PPD: _____ Date of Negative CXR: _____

Have you been treated with tuberculosis medication? ❑ Yes ❑ No

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

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

Do you have any of the following?

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

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

_____
_____
_____

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

Student's Signature: _____ Date: _____

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

VACCINE ALLERGY/WAIVER FORM

Vaccine	Contraindication to student receiving vaccine:	Initials
❑ TST/PPD ❑ Influenza ❑ TDAP ❑ Hepatitis B ❑ MMR ❑ Varicella	❑ Documented Allergy to Vaccine or Component of Vaccine ❑ **Pregnancy** EDC: _____ • Must be for live virus vaccine • Date Vaccine can safely be administered _____ ❑ Currently Immunosuppressed/Immunocompromised • Disease/Condition: _____ • Date Vaccine can be safely be administered _____	

- 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)

_____