### INSTRUCTIONS

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

**PLEASE MAKE SURE YOU MAKE COPIES OF ALL FORMS OR DOCUMENTS BEFORE SUBMITTING TO THE CLINICAL ADMISSIONS COORDINATOR**

<table>
<thead>
<tr>
<th>Program</th>
<th>Nursing</th>
<th>Phlebotomy</th>
<th>Med Tech</th>
<th>Paramedic</th>
<th>Soni Tech</th>
<th>Respiratory Care</th>
<th>PTA</th>
<th>OAS</th>
<th>Patient Care Tech</th>
<th>Pharmacy</th>
<th>Massage Therapy</th>
<th>EMT</th>
<th>Dental Assisting</th>
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## 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.

### Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Beach Urgent Care 843-626-2273</th>
<th>Carolina Health Pharmacy 843-215-8200</th>
<th>CVS Minute Clinic 866-389-2727</th>
<th>Doctor's Care 843-238-1461</th>
<th>Little River Medical Center 843-663-8000</th>
<th>Med Plus 843-357-2443</th>
<th>Passport Health 480-646-9038</th>
<th>Southern Urgent Care 843-357-4357</th>
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<tr>
<td>MMR Titer</td>
<td>$90.00</td>
<td>Sliding Scale</td>
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<td>Hep B Titer</td>
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Revised 10/02/2017 \[www.hgtc.edu\]
# Clinical Clearance Requirements

**ADN, PN, PHL, SURG TECH, PARAMEDICS, DMS, PATIENT CARE & RAD**

(please remit 1-sided copies of all records – you keep all originals)

<table>
<thead>
<tr>
<th>Form</th>
<th>Requirement</th>
<th>Criteria</th>
<th>Expires</th>
</tr>
</thead>
</table>
| 1.   | General Hospital Orientation (GHO) | Online Competency Certificate  
- See program website for instructions  
- Please print and remit Transcript to the Clinical Admissions Specialist | 1 Year |
| 2.   | CPR | Basic Life Support For Healthcare Providers Certification  
- Accept only American Heart Association (AHA) or American Red Cross (ARC)  
- Must provide CPR form as INITIAL proof of certification  
- Copy of BLS Card is REQUIRED | 2 Years |
| 3.   | Health Science Division Student Health Record | Physical (Pages 1-4)  
- Page 1 to be completed by the student  
- Page 2 to be completed and signed by the student  
- Page 2 must also be completed by your healthcare provider  
- Page 3 must be completed and signed by your healthcare provider  
- Page 4 must be completed and signed by the student | 1 Year |
| 4a.  | Tuberculin Skin Test / Purified Protein Derivative | Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)  
Step 1. Initial (Must be Read within 48-72 hours)  
Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)  
Semester PPD x 1  
To be completed 30-days prior to the start of EVERY semester | Each Semester |
| 4b.  | CXR | Chest x-ray (with documentation from physician stating any further treatment required)  
- Only to be done if you have a positive PPD/TST result  
- CXR are valid for two years unless symptomatic | |
| 4c.  | Symptom Assessment | Symptom Assessment  
- Complete form each semester if you have history of a positive PPD/TST with a negative CXR | |
| 5.   | Flu Vaccine | Flu Vaccine x 1  
- Based on prevalent strains each new season  
- Complete for Fall and Spring Semester Clinicals only | End of Flu Season |
| 6.   | TDAP (Adult) | TDAP Vaccine x 1  
- Td booster every 10 years after single adult TDAP dose | 10 Years |
| 7.   | Hepatitis B | Hepatitis B x 3 (recommended schedule below)  
Dose 1: Now  
Dose 2: 30 days after dose 1  
Dose 3: 5 months after dose 2  
Or POSITIVE Hep B titer  
Or Declination/Waiver Form (Page 4 of Health Record) | N/A |
| 8.   | Measles Mumps Rubella (MMR) | MMR  
POSITIVE MMR Titer Lab Results Are Required  
If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose # 2 must be administered 30 days after dose # 1.  
- Measles (Rubeola)  
- Mumps  
- Rubella (German Measles) | N/A |
| 9.   | Varicella | Varicella (Chickenpox)  
POSITIVE Varicella Titer Lab Results Are Required  
If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must begin 2-dose series immediately. Dose # 2 must be administered 30 days after dose # 1. | N/A |

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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# EXPANDED DUTY DENTAL ASSISTING AND DENTAL HYGIENE CLINICAL CLEARANCE REQUIREMENTS

(PLEASE REMIT 1-SIDED COPIES OF ALL RECORDS – YOU KEEP ALL ORIGINALS)

<table>
<thead>
<tr>
<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES:</th>
</tr>
</thead>
</table>
| 1.   | CPR         | Basic Life Support For Healthcare Providers Certification  
• Accept only American Heart Association (AHA) or American Red Cross (ARC)  
• Must provide CPR form as INITIAL proof of certification  
• Copy of BLS Card is REQUIRED | 2 Years |
| 2.   | HEALTH SCIENCE DIVISION STUDENT HEALTH RECORD | Physical (Pages 1-6)  
• Page 1 to be completed by the student  
• Page 2 to be completed and signed by the student  
• Page 2 must also be completed by your healthcare provider  
• Page 3 to be completed by the student  
• Page 4 to be completed by the student  
• Page 5 to be completed and signed by your healthcare provider  
• Page 6 to be completed by the student | 1 Year |
| 3a.  | TUBERCULIN SKIN TEST / PURIFIED PROTEIN DERIVATIVE | Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)  
Step 1. Initial (Must be Read within 48-72 hours)  
Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)  
Semester PPD x 1  
• To be completed 30-days prior to the start of EVERY semester | Each Semester |
| 3b.  | CXR         | Chest X-Ray (with documentation from physician stating any further treatment required)  
• Only to be done if you have a positive PPD/TST result  
• CXR are valid for two years unless symptomatic | 1 Year |
| 3c.  | SYMPTOM ASSESSMENT | Symptom Assessment  
• Complete form each semester if you have history of positive PPD/TST with negative CXR | 1 Year |
| 4.   | TDAP (ADULT) | TDAP Vaccine x 1  
• Td booster every 10 years after single adult TDAP dose | 10 Years |
| 5.   | HEPATITIS B | Hepatitis B x 3 (recommended schedule below)  
Dose 1: Now  
Dose 2: 30 days after dose 1  
Dose 3: 5 months after dose 2  
Or  
POSITIVE Hep B titer  
Or  
Declination/Waiver Form (Page 6 of Health Record) | N/A |
| 6.   | MEASLES MUMPS RUBELLA (MMR) | MMR  
• POSITIVE MMR Titer Lab Results Are Required  
• If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose # 2 must be administered 30 days after dose # 1.  
  ➢ Measles (Rubeola)  
  ➢ Mumps  
  ➢ Rubella (German Measles)  
• If Titers are NEGATIVE or EQUIVOCAL = MMR X 2  
• If Titers are NEGATIVE or EQUIVOCAL = MMR X 2  
• If Titers are NEGATIVE or EQUIVOCAL = MMR X 1 | N/A |
| 7.   | VARICELLA   | Varicella (Chickenpox)  
• POSITIVE Varicella Titer Lab Results Are Required  
• If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must begin 2-dose series immediately. Dose # 2 must be administered 30 days after dose # 1. | N/A |
| 8.   | INSURANCE   | HPSO Liability Insurance Policy  
• Policy Coverage - $1,000,000 each claim professional liability coverage  
$3,000,000 aggregate professional liability coverage | 1 Year |

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to start of that semester

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**EMT CLINICAL CLEARANCE REQUIREMENTS**

*(PLEASE REMIT 1-SIDED COPIES OF ALL RECORDS – YOU KEEP ALL/originals)*

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<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES:</th>
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<td>CPR</td>
<td>Basic Life Support For Healthcare Providers Certification</td>
<td>2 Years</td>
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<tr>
<td></td>
<td></td>
<td>• Accept only American Heart Association (AHA) or American Red Cross (ARC)</td>
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<td>• Must provide CPR form as INITIAL proof of certification</td>
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<td></td>
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<td>• Copy of BLS Card is REQUIRED</td>
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<td>2.</td>
<td>HEALTH SCIENCE</td>
<td>Physical (Pages 1-4)</td>
<td>1 Year</td>
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<td>DIVISION STUDENT</td>
<td>HEALTH RECORD</td>
<td>• Page 1 to be completed by the student</td>
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<td></td>
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<td>• Page 2 to be completed and signed by the student</td>
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<td></td>
<td></td>
<td>• Page 2 must also be completed by your healthcare provider</td>
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<td></td>
<td>• Page 3 must be completed and signed by your healthcare provider</td>
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<tr>
<td></td>
<td></td>
<td>• Page 4 must be completed and signed by the student</td>
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<td>3a.</td>
<td>TUBERCULIN SKIN TEST /</td>
<td>Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)</td>
<td>Each Semester</td>
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<tr>
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<td>PURIFIED PROTEIN DERIVATIVE</td>
<td>Step 1. Initial (Must be Read within 48-72 hours)</td>
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<td></td>
<td>Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)</td>
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<tr>
<td></td>
<td></td>
<td>Semester PPD x 1</td>
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<td></td>
<td>To be completed 30-days prior to the start of EVERY semester</td>
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<td>3b.</td>
<td>CXR</td>
<td>Chest x-ray (with documentation from physician stating any further treatment required)</td>
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<td>• Only to be done if you have a positive PPD/TST result</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• CXR are valid for two years unless symptomatic</td>
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<td>3c.</td>
<td>SYMPTOM ASSESSMENT</td>
<td>Symptom Assessment</td>
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<td>Complete form each semester if you have history of a positive PPD/TST with a negative CXR</td>
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<td>4.</td>
<td>FLU VACCINE</td>
<td>Flu Vaccine x 1</td>
<td>End of Flu Season</td>
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<td></td>
<td>• Based on prevalent strains each new season</td>
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<tr>
<td></td>
<td></td>
<td>• Complete for Fall and Spring Semester Clinicals only</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>HEPATITIS B</td>
<td>Hepatitis B x 3 (recommended schedule below)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dose 1: Now                                      Dose 2: 30 days after dose 1                  Dose 3: 5 months after dose 2</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Or: POSITIVE Hep B titer</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Or: Declination/Waiver Form (Page 4 of Health Record)</td>
<td></td>
</tr>
</tbody>
</table>

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER/DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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# MASSAGE THERAPY CLINICAL CLEARANCE REQUIREMENTS

(PLEASE REMIT 1-SIDED COPIES OF ALL RECORDS – YOU KEEP ALL ORIGINALS)

<table>
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<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES</th>
</tr>
</thead>
</table>
| 1.   | HEALTH SCIENCE DIVISION STUDENT HEALTH RECORD | Physical (Pages 1-4)  
- Page 1 to be completed by the student  
- Page 2 to be completed and signed by the student  
- Page 2 must also be completed by your healthcare provider  
- Page 3 must be completed and signed by your healthcare provider  
- Page 4 must be completed and signed by the student | 1 Year |
| 2a.  | TUBERCULIN SKIN TEST / PURIFIED PROTEIN DERIVATIVE | Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)  
- Step 1. Initial (Must be Read within 48-72 hours)  
- Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)  
**Semester PPD x 1**  
To be completed 30-days prior to the start of EVERY semester | Each Semester |
| 2b.  | CXR | Chest x-ray (with documentation from physician stating any further treatment required)  
- Only to be done if you have a positive PPD/TST result  
CXR are valid for two years unless symptomatic |  |
| 2c.  | SYMPTOM ASSESSMENT | Symptom Assessment  
- Complete form each semester if you have history of a positive PPD/TST with a negative CXR |  |
| 3.   | TDAP (ADULT) | TDAP Vaccine x 1  
- Td booster every 10 years after single adult TDAP dose | 10 years |
| 4.   | HEPATITIS B | **Hepatitis B x 3** (recommended schedule below)  
**Dose 1:** Now  
**Dose 2:** 30 days after dose 1  
**Dose 3:** 5 months after dose 2  
**Or**  
- POSITIVE Hep B titer  
**Or**  
- Declination/Waiver Form (Page 4 of Health Record) | N/A |
| 5.   | MEASLES MUMPS RUBELLA (MMR) | MMR  
- POSITIVE MMR Titer Lab Results Are Required  
- If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose #2 must be administered 30 days after dose #1.  
- Measles (Rubeola)  
  - IF NEG or EQUIVOCAL = MMR X 2  
- Mumps  
  - IF NEG or EQUIVOCAL = MMR X 2  
- Rubella (German Measles)  
  - IF NEG or EQUIVOCAL = MMR X 1 | N/A |

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined  
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted  
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.  
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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### PHARMACY TECH CLINICAL CLEARANCE REQUIREMENTS

(PLEASE REMIT 1-SIDED COPIES OF ALL RECORDS – YOU KEEP ALL ORIGINALS)

<table>
<thead>
<tr>
<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>GENERAL HOSPITAL ORIENTATION (GHO)</td>
<td>Online Competency Certificate</td>
<td>1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See program website for instructions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Please print and remit Transcript to the Clinical Admissions Specialist</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>CPR</td>
<td>Basic Life Support For Healthcare Providers Certification</td>
<td>2 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accept only American Heart Association (AHA) or American Red Cross (ARC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Must provide CPR form as INITIAL proof of certification</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of BLS Card is REQUIRED</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>HEALTH SCIENCE DIVISION STUDENT HEALTH RECORD</td>
<td>Physical (Pages 1-4)</td>
<td>1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Page 1 to be completed by the student</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Page 2 to be completed and signed by the student</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Page 2 must also be completed by your healthcare provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Page 3 must be completed and signed by your healthcare provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Page 4 must be completed and signed by the student</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Semester PPD x 1</td>
<td>Each Semester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be completed 30-days prior to the start of EVERY semester</td>
<td></td>
</tr>
<tr>
<td>4a.</td>
<td>TUBERCULIN SKIN TEST / PURIFIED PROTEIN DERIVATIVE</td>
<td>Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)</td>
<td>Each Semester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Step 1. Initial (Must be Read within 48-72 hours)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Semester PPD x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be completed 30-days prior to the start of EVERY semester</td>
<td></td>
</tr>
<tr>
<td>4b.</td>
<td>CXR</td>
<td>Chest x-ray (with documentation from physician stating any further treatment required)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Only to be done if you have a positive PPD/TST result</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CXR are valid for two years unless symptomatic</td>
<td></td>
</tr>
<tr>
<td>4c.</td>
<td>SYMPTOM ASSESSMENT</td>
<td>Symptom Assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complete form each semester if you have history of a positive PPD/TST with a negative CXR</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>FLU VACCINE</td>
<td>Flu Vaccine x 1</td>
<td>End of Flu Season</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Based on prevalent strains each new season</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Complete for Fall and Spring Semester Clinicals only</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>TDAP (ADULT)</td>
<td>TDAP Vaccine x 1</td>
<td>10 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Td booster every 10 years after single adult TDAP dose</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>HEPATITIS B</td>
<td>Hepatitis B x 3 (recommended schedule below)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dose 1: Now Dose 2: 30 days after dose 1 Dose 3: 5 months after dose 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Or POSITIVE Hep B titer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Or Declination/Waiver Form (Page 4 of Health Record)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>MEASLES MUMPS RUBELLA (MMR)</td>
<td>MMR</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• POSITIVE MMR Titer Lab Results Are Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If Titers are NEGATIVE or EQUIVOCA LA, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose # 2 must be administered 30 days after dose # 1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Measles (Rubeola) If NEG or EQUIVOCAL = MMR X 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mumps If NEG or EQUIVOCAL = MMR X 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rubella (German Measles) If NEG or EQUIVOCAL = MMR X 1</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>VARICELLA</td>
<td>Varicella (Chickenpox)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• POSITIVE Varicella Titer Lab Results Are Required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If Titers are NEGATIVE or EQUIVOCA LA, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must begin 2-dose series immediately. Dose # 2 must be administered 30 days after dose # 1.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>BOARD OF PHARMACY</td>
<td>Current South Carolina Board of Pharmacy Certification</td>
<td>June 30th</td>
</tr>
<tr>
<td>11.</td>
<td>INSURANCE</td>
<td>HPSO Liability Insurance Policy</td>
<td>1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Policy Coverage: $1,000,000 each claim professional liability coverage and $3,000,000 aggregate professional liability coverage</td>
<td></td>
</tr>
</tbody>
</table>

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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PTA CLINICAL CLEARANCE REQUIREMENTS

(PLEASE REMIT 1-SIDED COPIES OF ALL RECORDS – YOU KEEP ALL ORIGINALS)

<table>
<thead>
<tr>
<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES:</th>
</tr>
</thead>
</table>
| 1.   | GENERAL HOSPITAL ORIENTATION (GHO) | Online Competency Certificate  
- See program website for instructions  
- Please print and remit Transcript to the Clinical Admissions Specialist | 1 Year |
| 2.   | CPR | Basic Life Support For Healthcare Providers Certification  
- Accept only American Heart Association (AHA) or American Red Cross (ARC)  
- Must provide CPR form as INITIAL proof of certification  
- Copy of BLS Card is REQUIRED | 2 Years |
| 3.   | HEALTH SCIENCE DIVISION STUDENT HEALTH RECORD | Physical (Pages 1-4)  
- Page 1 to be completed by the student  
- Page 2 to be completed and signed by the student  
- Page 2 must also be completed by your healthcare provider  
- Page 3 must be completed and signed by your healthcare provider  
- Page 4 must be completed and signed by the student | 1 Year |
| 4a.  | TUBERCULIN SKIN TEST / PURIFIED PROTEIN DERIVATIVE | Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)  
- Step 1. Initial (Must be Read within 48-72 hours)  
- Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours) | Each Semester |
| 4b.  | CXR | Chest x-ray (with documentation from physician stating any further treatment required)  
- Only to be done if you have a positive PPD/TST result  
- CXR are valid for two years unless symptomatic | | |
| 4c.  | SYMPTOM ASSESSMENT | Symptom Assessment  
- Complete form each semester if you have history of a positive PPD/TST with a negative CXR | | |
| 5.   | FLU VACCINE | Flu Vaccine x 1  
- Based on prevalent strains each new season  
- Complete for Fall and Spring Semester Clinics only | End of Flu Season |
| 6.   | TDAP (ADULT) | TDAP Vaccine x 1  
- Td booster every 10 years after single adult TDAP dose | 10 Years |
| 7.   | HEPATITIS B | Hepatitis B x 3 (recommended schedule below)  
- Dose 1: Now  
- Dose 2: 30 days after dose 1  
- Dose 3: 5 months after dose 2  
Or POSITIVE Hep B titer  
Or Declination/Waiver Form (Page 4 of Health Record) | N/A |
| 8.   | MEASLES MUMPS RUBELLA (MMR) | MMR  
- POSITIVE MMR Titer Lab Results Are Required  
- If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose # 2 must be administered 30 days after dose # 1.  
- Measles (Rubeola)  
- Mumps  
- Rubella (German Measles) | N/A |
| 9.   | VARICELLA | Varicella (Chickenpox)  
- POSITIVE Varicella Titer Lab Results Are Required  
- If Titers are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must begin 2-dose series immediately. Dose # 2 must be administered 30 days after dose # 1. | N/A |
| 10.  | INSURANCE | HPSO Liability Insurance Policy  
- Policy Coverage: $1,000,000 each claim professional liability coverage and $3,000,000 aggregate professional liability coverage | 1 Year |

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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RESPIRATORY CARE CLINICAL CLEARANCE REQUIREMENTS

(Please make copies of all records before submitting)

<table>
<thead>
<tr>
<th>FORM</th>
<th>REQUIREMENT</th>
<th>CRITERIA</th>
<th>EXPIRES</th>
</tr>
</thead>
</table>
| 1.   | GENERAL HOSPITAL ORIENTATION (GHO) | ONLINE COMPETENCY CERTIFICATE  
• See program website for instructions  
• Please print and remit Transcript to the Clinical Admissions Specialist | 1 Year |
| 2.   | CPR | BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS CERTIFICATION  
• Accept only American Heart Association (AHA) or American Red Cross (ARC)  
• Must provide CPR form as INITIAL proof of certification  
• Copy of BLS Card is REQUIRED | 2 Years |
| 3.   | HEALTH SCIENCE DIVISION STUDENT HEALTH RECORD | Physical (Pages 1-4)  
• Page 1 to be completed by the student  
• Page 2 to be completed and signed by the student  
• Page 2 must also be completed by your healthcare provider  
• Page 3 must be completed and signed by your healthcare provider  
• Page 4 must be completed and signed by the student | 1 Year |
| 4a.  | TUBERCULIN SKIN TEST / PURIFIED PROTEIN DERIVATIVE | Initial PPD/TST x 2 (required even if student had BCG without documentation of 2 step)  
Step 1. Initial (Must be Read within 48-72 hours)  
Step 2. 1 week after reading of Step 1 (Must be Read within 48-72 hours)  
Semester PPD x 1  
• To be completed 30-days prior to the start of EVERY semester | Each Semester |
| 4b.  | CXR | Chest x-ray (with documentation from physician stating any further treatment required)  
• Only to be done if you have a positive PPD/TST result  
• CXR are valid for two years unless symptomatic |  |
| 4c.  | SYMPTOM ASSESSMENT | Symptom Assessment  
• Complete form each semester if you have history of a positive PPD/TST with a negative CXR |  |
| 5.   | FLU VACCINE | Flu Vaccine x 1  
• Based on prevalent strains each new season  
• Complete for Fall and Spring Semester Clinicals only | End of Flu Season |
| 6.   | TDAP (ADULT) | TDAP Vaccine x 1  
• Td booster every 10 years after single adult TDAP dose | 10 Years |
| 7.   | HEPATITIS B | Hepatitis B x 3 (recommended schedule below)  
Dose 1: Now  
Dose 2: 30 days after dose 1  
Dose 3: 5 months after dose 2  
Or POSITIVE Hep B titer  
Or Declination/Waiver Form (Page 4 of Health Record) | N/A |
| 8.   | MEASLES MUMPS RUBELLA (MMR) | MMR  
• POSITIVE MMR Titer Lab Results Are Required  
• If Titters are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must receive the following doses. Dose # 2 must be administered 30 days after dose # 1.  
  ➢ Measles (Rubeola)  
  ➢ Mumps  
  ➢ Rubella (German Measles)  
• N/A |
| 9.   | VARICELLA | VARICELLA  
• POSITIVE Varicella Titer Lab Results Are Required  
• If Titters are NEGATIVE or EQUIVOCAL, student must provide immunization records documenting receipt of 2-dose series plus receive a new 1-dose booster vaccine immediately. If 2-dose series documentation cannot be provided, student must begin 2-dose series immediately. Dose # 2 must be administered 30 days after dose # 1. | N/A |
| 10.  | RADIATION EXPOSURE WAIVER | Waiver of Liability | N/A |

- Titers must be provided on actual laboratory report with values & reference ranges clearly defined
- Healthcare Provider (HCP) documentation of “immune” or “positive” not accepted
- WAIVER /DECLINATION accepted only for HCP documented allergy to immunization/component of immunization; certain exclusions may apply to pregnant individuals.
- If renewal/expiration falls within a semester, the renewal must be completed prior to beginning of that semester

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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 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 and 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>• <strong>You will need to manually add these two modules:</strong></td>
</tr>
<tr>
<td>Fire Safety</td>
<td>• <strong>Tidelands, Conway, Grand Strand, Waccamaw (GHO)</strong></td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>• <strong>Tidelands Health – Ebola Preparedness</strong></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@htgc.edu.
Health Science Division – Student Health Record

Student Name: ____________________________
Student H#________________________________
Program: ______________________________

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: 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 Information
(Prices and Information Subject To Change)

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

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

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

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

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

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 cglimore@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.pdrem.com
http://www.pdrem.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

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

_________________________________________________________________________________

Please list any other medical conditions not addressed above:

_________________________________________________________________________________

Please list all medications that you are currently taking:

_________________________________________________________________________________

| Student Name: ________________________________ | Student H#_____________________________ | Program: ____________________________________________________________________ |

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

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

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

(PROGRAM NAME)

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

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

<table>
<thead>
<tr>
<th>Does the student have any restrictions/limitations?</th>
<th>Yes</th>
<th>_______</th>
<th>No</th>
<th>_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how many weeks are restrictions/limitations in effect:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what date will the restrictions/limitations be lifted:</td>
<td></td>
<td></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>_______</td>
<td>No</td>
<td>_______</td>
</tr>
<tr>
<td>If yes, date of scheduled appointment for follow-up:</td>
<td></td>
<td></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 ________________
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>
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<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney/Bladder Abnormality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ALLERGIES: ____________________________ 

<table>
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<tr>
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<td>Kidney/Bladder Abnormality</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you answered “yes” to any question, please give dates and treatments:

__________________________________________________________________________
__________________________________________________________________________
Please list any other medical conditions not addressed above:

__________________________________________________________________________

Please list all medications that you are currently taking:

__________________________________________________________________________

Student Signature ___________________________ Date ____________________________

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

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

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

Corrected Vision:  RIGHT: 20/ _____  LEFT: 20/ _____  Hearing: (Please circle)

RIGHT: Normal  Impaired  LEFT: Normal  Impaired

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

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

Form 3a; Revised 10/02/2017 \ www.hgtc.edu
Student Name: ________________________________
Student H#___________________________________
Program: ____________________________________

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:

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

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

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

<table>
<thead>
<tr>
<th>Does the student have any restrictions/limitations?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, how many weeks are restrictions/limitations in effect:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what date will the restrictions/limitations be lifted:</td>
<td></td>
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<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

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>
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<td>□ Negative</td>
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<td>□ Positive</td>
<td>_____ mm</td>
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<tr>
<td>Step 2</td>
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<td></td>
<td>□ Negative</td>
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<td></td>
<td></td>
<td>□ Positive</td>
<td>_____ mm</td>
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<tr>
<td>Semester</td>
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<td></td>
<td></td>
<td></td>
<td>□ Negative</td>
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<td></td>
<td></td>
<td></td>
<td>□ Positive</td>
<td>_____ mm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• An initial 2-Step PPD and Semester PPDs are required for all Allied Health programs.
• Step 2 should be administered 7 days after Step 1 has been read.
• Semester PPD should be administered and read within 60-days prior to the start of each semester.
• 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 1\textsuperscript{st} time positive PPD)

<table>
<thead>
<tr>
<th>CXR Date:</th>
<th>Result:</th>
<th>Initials:</th>
</tr>
</thead>
</table>

NOTE: Copy of actual result must be attached.

- 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

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

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

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

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

Form 4b: Revised 10/02/2017 \ www.hgtc.edu
SYMPTOM ASSESSMENT FROM
(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: ______________
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
**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>
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<td></td>
<td></td>
</tr>
<tr>
<td>Booster</td>
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<td></td>
</tr>
</tbody>
</table>

**Certification:**

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

_______________________________________________________________________

Signature

_______________________________________________________________________

Signature

_______________________________________________________________________

Signature

- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.
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>
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<td>2.</td>
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<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

Positive Titer Results Are Required

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.

<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>
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<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.

- Titer result must be accompanied by actual lab result with score and reference ranges clearly designated.

Form 8; Revised 10/02/2017 \ www.hgtc.edu
VARICELLA (CHICKENPOX) FORM

Positive Titer Results Are Required

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>
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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 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.

- Titer result must be accompanied by actual lab result with score and reference ranges clearly designated.

Form 9, Revised 10/02/2017  \ 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>
</tbody>
</table>
| Influenza      | **Pregnancy** EDC: __________________  
                   - Must be for live virus vaccine                                                                 |          |
| TDAP           | Date Vaccine can safely be administered __________________                                                       |          |
| Hepatitis B    | **Currently Immunosuppressed/Immunocompromised**                                                                  |          |
| MMR            | **Currently Immunosuppressed/Immunocompromised**                                                                  |          |
| Varicella      | **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.

---

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title (MD, NP, PA)</th>
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<table>
<thead>
<tr>
<th>Signature</th>
<th>Title (MD, NP, PA)</th>
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</table>
HPSO LIABILITY INSURANCE

Required For The Following Programs:

Dental Assisting (DAT)
Dental Hygiene (DHG)
Pharmacy (PHM)
Physical Therapy (PTH)

Visit www.hpso.com
Select “Get a Quote – Apply Now”
Select “Individual” and “Continue”
Follow the prompts.
Be sure to purchase $1,000,000 for 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 11/19/2015, the premium cost was $35.00. Prices are subject to change.

Revised 10/02/2017 \ www.hgtc.edu
INSTRUCTIONS FOR PHARMACY TECHNICIAN REGISTRATION

IMPORTANT: KEEP THIS PAGE FOR YOUR RECORDS

To become a Pharmacy Technician, you must complete the Pharmacy Technician Registration Application, Affidavit of Eligibility Form and submit a copy of your driver’s license or DMV picture ID.

Examination

A person applying to become a registered Pharmacy Technician is not required to take an examination to become a registered Pharmacy Technician.

Employment

After you have received your registration and begin employment, you must notify the Board in writing of your employment or submit the Change of Employment form whenever you begin or change employment. The form is available on the Board of Pharmacy website: www.llr.sc.gov/pol/pharmacy.

Continuing Education

In order to renew your registration each year, you must complete ten hours of continuing education. Four (4) of those hours must be live. All CE hours must be completed before you actually renew the registration.

List of available web sites for CE (Continuing Education) credits


Only ACPE courses are accepted. To determine if a course is L (live) or H (home), the ACPE UPN# will look like this example:

430-000-09-021–H01 or 430-000-09-021–L01

Valid Pharmacy Technician Registration

Registrations are valid from July 1 through June 30th each year.
PHARMACY TECHNICIAN REGISTRATION APPLICATION

All information requested on this application is mandatory. Failure to provide any requested information will result in the application being returned as incomplete. Personal information provided in this application may be subject to public scrutiny or release under the S.C. Freedom of Information Act or other provision of federal and state law.

Non-Refundable $40.00 Fee Check or Money Order payable to SC Board of Pharmacy.

Full Name: _____________________________________________________________________________________________

Last     First     Middle

Address: _____________________________________________________________________________________________

(INCLUDING STREET & APARTMENT NUMBERS)

City  County  State  Zip Code

Home Phone: (______) _________________________  Cell Phone: (______) _________________________

Work Phone: (______) _________________________  Date of Birth: _____/_____/_______

Email: ________________________________________  Place of Birth: __________________________________________

City  State

Social Security Number _____/_____/_______

Race: (for statistical purposes only)

[ ] American Indian  [ ] African American  [ ] Caucasian  [ ] Hispanic  [ ] Oriental/Asian  [ ] Other

Marital Status: [ ] Single  [ ] Married  [ ] Widowed  [ ] Divorced

Sex: [ ] Female  [ ] Male

(1) In the last five years, have you ever been treated for any condition, be it physical, mental, or emotional that could impair your ability to serve as a pharmacy technician?

_____ *YES  _____ NO

If your answer is “Yes”, attach a full written explanation and include documents from your Physician. Information of a highly personal nature will be protected under The Freedom of Information Act.

(2) Have you ever been convicted of any criminal or civil charges (other than a minor traffic ticket)? Is there any legal action pending against you or are you currently on probation for any charges or legal action?

_____ *YES  _____ NO

If your answer is “Yes”, attach a full written explanation and include certified copies of any pertinent legal and/or court documents. Information of a highly personal nature will be protected under The Freedom of Information Act.
(3) Have you ever held a pharmacist license, pharmacy technician registration or intern certificate? _____ *YES    _____ NO
If so, has the license/registration/certificate ever been disciplined? _____ *YES  ______ NO

High School Graduate?      ____ Yes   ____ No                                             Received GED?  ____ Yes   ____ No
Graduate of Pharmacy Technician Program?   ____ Yes     ____ No
On the Job Training as a Pharmacy Technician?     ____ Yes     ____ No
Are you Nationally Certified as a Pharmacy Technician?    ____ Yes ____ No
How many years of experience do you have as a pharmacy technician?  ____________

IMPORTANT

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

If you are completing this registration form before April 1st, you are required to renew your registration by June 30th. Be advised that you must complete the 10 (4 live and 6 home) continuing education hours before renewing your pharmacy technician registration.

I hereby certify that I have answered all questions truthfully, accurately and completely, and acknowledge that failure to do so shall constitute cause for denial of registration. I understand that I must complete 10 hours of continuing education courses (4 live, 6 home study or all live) Before renewing my registration each year.

______________________________    ______________________________
Signature        Date

When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee through electronic fund transfer from your account if your payment is returned unpaid. Please provide the following on your check: Drivers License#; Full Name; Street Address and Phone Numbers.

All information requested on this application is mandatory. Failure to provide any requested information will result in the application being returned as incomplete. Personal information provided in this application may be subject to public scrutiny or release under the S. C. Freedom of Information Act or other provision of federal and state law.
INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:
If you are a United States Citizen by birth or naturalization

CHECK box 2:
If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:
If you are a Qualified Alien. You are a Qualified Alien if you are:
An alien who is lawfully admitted for residence under the INA.
An alien who is granted asylum under Section 208 of the INA.
A refugee who is admitted to the United States under Section 207 of the INA.
An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.
An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).
An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.
An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.
An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:
Unexpired Reentry Permit (I-327)
Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)
Unexpired Refugee Travel Document (I-571)
Unexpired Employment Authorization Card Which Contains a Photograph (I-766)
Machine Readable Immigrant Visa (with Temporary I-551 Language)
Temporary I-551 Stamp (on passport or I-94)
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)
DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)
Pursuant to Section 8-29-10, et seq. of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned ____________________________, of ____________________________
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:
1. ☐ I am a United States citizen; or
2. ☐ I am a Legal Permanent Resident of the United States eighteen years of age or older; or
3. ☐ I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.
4. ☐ Other: ____________________________ Please submit any documentation that supports this status.

Date of Birth: ____________________________

Alien Number: ____________________________ I-94 Number: ____________________________

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

________________________________________
Signature of Affiant

SWORN to before me this _______ day of ___________ 20__________

Notary Signature

________________________________________
Print Name

Notary Public for ____________________________

My Commission Expires: ____________________________

Rev: 02-02-2015
Enclose with Application:

☐ Non-Refundable $40.00 Fee Check or Money Order payable to SC Board of Pharmacy.

☐ Copy of Driver’s License or DMV picture ID

☐ Verification of Lawful Presence-Affidavit of Eligibility

☐ Copy of Social Security Card

Mail to:  S.C. Board of Pharmacy
          P O Box 11927
          Columbia, SC  29211-1927

When you provide a check as payment, you authorize us to use information from the check to make a one-time electronic fund transfer from your account, or to process the payment as a check transaction. You authorize us to collect a fee through electronic fund transfer from your account if your payment is returned unpaid. Please provide the following on your check: Drivers License #; Full Name; Street Address and Phone Numbers.

EMPLOYMENT - After you have received your registration and begin employment, you must notify the Board in writing or by submitting the Change of Employment form whenever you begin or change employment. The form is available on the Board of Pharmacy website: www.llronline.com/pol/pharmacy.

*PLEASE DO NOT RETURN THIS PAGE WITH YOUR APPLICATION. THIS IS FOR YOUR RECORDS.*
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 (Coccidiodomycosis); 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.
HORRY GEORGETOWN TECHNICAL COLLEGE

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
Please Print Your Information

NON-EMPLOYEES ID CARD AUTHORIZATION

SSN: ___________________________ DOB: ___________________________

Legal First Name: ___________________ MI: _____ Last Name: ___________________

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

Gender: □ M □ F

Address:__________________________________________________________________________
_________________________________________________________________________________

City: ___________________________ State: ___________ Zip Code: ___________

County: _________________________ Telephone Number: __________________________

Cell Number: ___________________ School: _________________________________________

Email Address: _____________________

Start Date: ______________________ Stop Date: _________________________________

McLeod Department (for clinical rotation): _________________________________________

Present or Past Employee of McLeod Health ______ yes ______ no

Location of Rotation: ____________________________________________________________

(Florence, Darlington, Dillon, Loris, Seacoast)

TO BE COMPLETED BY MCLEOD HUMAN RESOURCES:

Department Director: ________________Job Code #: ____________Cost Center #: ____________