INFORMATION PACKET

NEW OTA STUDENT CHECKLIST

Please read carefully!

		Deadlines
Step 1	**Physical Form** – Make your appointment date as soon as possible. ***Dates are important*** – Check the boxes when completed! Be SURE your Health Care Provider has documented in ***all*** the spaces. Complete Physical form on both sides ☐ Side 1 completed by student, Side 2 completed by Health Care Provider ☐ 2-Step TB Skin Test with placement dates, reading dates, and results. First test is placed, read with 48-72 hours. Student returns in the same week for second placement. Second test is placed, read 48-72 hours later. After the initial 2-step TB skin test, students will complete an annual 1-step test. Chest x-ray required if TB skin test is positive. ☐ Tetanus (TDAP) with date (must have been received within previous 10 years) ☐ (2) MRs with date or rubella AND rubella AND mumps titers that indicate immunity ☐ (3) Hepatitis B vaccine dates or Hepatitis B titer that indicates immunity ☐ (2)Varicella vaccine dates or Varicella titer that indicates immunity ☐ Current season flu shot (student will submit flu shot annually as seasonal flu shot becomes available) *If titers are drawn to show immunity, **titer report listing results and immunity reference ranges** must be submitted with the physical form. Contraindications for MMR, Hep B, or Varicella must be documented by Healthcare Provider.* *****STUDENT MUST TURN IN ORIGINAL PHYSICAL FORM FROM THE HEALTH PROGRAMS OFFICE. NO COPIES OR UNOFFICIAL FORMS WILL BE ACCEPTED. PHYSICALS WILL BE CURRENT FOR 2 CALENDAR YEARS FROM THE DATE OF ADMISSIONS AS LONG AS THE STUDENT MAINTAINS CONTINUOUS ENROLLMENT. *****	**Student is responsible for making his/her own appointment.** **Health Care Provider must complete original *yellow* physical form.** **Submit August 13**
Step 2	**Certificate of Insurance** Go to: **WWW.HPSO.COM** (1.800.982-9491) – Click on Get a Quote, follow application guidelines. Make coverage effective first day of class. Please have confirmation and verification copy printed.	**Submit August 13**
Step 3	**Flu Shot** - Some clinical agencies require current flu shot documentation. If you are required to complete a flu shot for your assigned clinical agency, you will be notified to do so prior to clinical orientation.	**ASAP**
Step 4	**CPR:** Submit copy of front/back of CPR Card. Completion card ***must*** be ***American Heart Association, Health Care Provider BLS.*** No other types of CPR will be accepted. Students may contact the American Heart Association or consult the American Heart Association website to locate AHA Health Care Provider BLS courses.	**Submit August 13**
Step 5	**Immunization Verification Form** –The immunization verification form for Hepatitis B, MMRs, and Varicella must be completed, signed and dated in addition to the physical form.	**Submit August 13**
Step 6	**Health Insurance Consent Form** – Initial beside each statement, sign, and date. Submit copy of current Health Insurance card with form if applicable.	
Step 7	**OTA Student and Clinical Education Handbook**: Download the 2018-2019 OTA Student and Clinical Education Handbooks from the OTA website. http://ws.edu/academics/health/occupational-therapy-assistant/ Read prior to signing your consent forms.	**Submit August 13**
Step 8	**Consent Forms** - Please complete and/or sign: 1) Consent Form; 2) Student Conduct Form; 3) HIPPA (Privacy agreement); 4) Authorization for Release of Student Information and Acknowledgement (Criminal Background) form; 5) Drug/Alcohol Abuse Policy (a portion of this info is in your handbook that you are required to read); 6) Requirement to Participate as the Role of "Patient" form.	
Step 9	**Criminal Background Check:** A Truescreen criminal background check is required for participation in most clinical experiences. Students will be required to submit a clear background check to requesting clinical facilities. Instructions for ordering your background check are included in this packet.	
Step 10	**Drug Screen** - Some clinical agencies require drug screens. If you are required to complete a drug screen for your assigned clinical agency, you will be notified to do so prior to clinical orientation. **Drug screens will be ordered through Truescreen. See Instructions for completion in the packet.**	**Submit August 13**
Step 11	**Photos** - Two (2) photos - 2x2 headshot (passport style) with signature on back.	
Step 12	**MAKE A COPY OF ALL DOCUMENTATION BEFORE SUBMITTING! Professional development implies that YOU maintain personal records of the above. Documentation submitted will not be returned for any reason.**	
Step 13	**Completed information packet must be submitted AT ORIENTATION. No exceptions.**	

Criminal Background checks may be a requirement for training at some affiliated clinical sites. Based on the results of these checks, an affiliated clinical site may determine to not allow your presence at a facility. Additionally, a criminal background may preclude licensure or employment. If you are assigned to a clinical affiliate requiring a criminal background check, you will be required to provide the requested information. Acceptance of you as a student in the clinical facility will be at the clinical affiliate's discretion. As a student, you will be responsible for the cost of any required background checks. If a clinical affiliate denies your presence in the facility, you will not be able to complete the clinical/practicum and you will be withdrawn from the program. The specifications for the background check are at the discretion of the clinical affiliate. Should the affiliate not require a specific vendor for the check, the program director will provide a list of available vendors to purchase the required criminal background check. The exact amount may vary based on the affiliate specifications and individual student differences. As a student you will not be allowed access to a clinical facility for any student experience until the clinical facility has authorized your presence.

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
IMMUNIZATION VERIFICATION

Due to your potential risk for exposure to blood or other potentially infectious materials, you may be at risk of acquiring Hepatitis B Virus (HBV) infection, measles, mumps, rubella, or varicella (chicken pox). Health Programs students must provide documentation of **complete vaccinations** or **titers showing immunizations** from their healthcare provider.

Indicate one choice of action to each vaccination listed below. YOU MUST HAVE AT LEAST ONE OF THESE CHECKED FOR EACH.

I. Hepatitis B (HBV):*

_____Documentation of three (3) shot dates.
_____Titer showing immunity status to Hepatitis B.**
_____Documentation from my health care provider stating reason for contraindication.***
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.***

II. MMR (Measles, Mumps, Rubella): *

_____Documentation of two (2) shot dates.
_____Titers showing immunity status to rubella, rubeola and mumps. **
_____Documentation from my health care provider stating reason for contraindication.***
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.***

III. Varicella (Chicken Pox): *

_____Documentation of two (2) shot dates.
_____**Titer showing immunity status to varicella.****
_____Documentation from my health care provider stating reason for contraindication.***
_____Signed written statement affirmed under penalty of perjury stating conflict with religious beliefs.***

A student may be exempt from this requirement under one of the following circumstances: *

1) The vaccine is contraindicated for the individual based on guidelines established by manufacturer or Center for Disease Control
2) Physician judgment based on the individual's medical condition and history – (risk of harm outweighs benefit)
3) Religious belief or practice – (individual must provide written statement affirmed under penalty of perjury).

I have read and understand this information. I have made a selection for each vaccination.

_____ _____
STUDENT SIGNATURE DATE

_____ _____
AFWC SIGNATURE DATE

***** *Acceptance of you as a student in a clinical facility will be at the clinical affiliate's discretion. If a clinical affiliate denies your presence, you will not be able to complete the clinical\practicum and you will be withdrawn from the program.*

****Students who provide titers with laboratory values inconsistent with immunity are encouraged to get the vaccinations.*

*****Student must submit documentation for medical or religious contraindications.*

WALTERS STATE COMMUNITY COLLEGE
STATEMENT OF UNDERSTANDING: HIPAA and SOCIAL MEDIA

Being health care professionals, you now need to consider the following social network guidelines to ensure you are not unintentionally noncompliant with HIPAA regulations.

1. When speaking with your peers while in the program, you must also recognize you cannot share any specific patient information on Facebook, Twitter, etc.

2. It is a HIPAA violation if you mention a client/patient with enough information that the person might be identified, even in you avoid PHI. The consequences for violations, as you know, are severe. For more information: http://www.aota.org/Education-Careers/Fieldwork/Supervisor/HIPAA.aspx

3. Names of supervisors, comments, and /or criticism about sites or information about what is happening at sites are not appropriate on public social network sites.

4. Students should not put posts or photos on social networks about lab or fieldwork experiences (including location, clients, diagnosis, treatment, fieldwork educators, and staff etc…)

5. Stating where you are on FW is up to you, but there are problems with you being identified. Consider if you want privacy from client, patients, and staff.

6. Use your official WSCC e-mail or a personal e-mail that is tasteful and confidential for all professional correspondence.

7. Do not ask faculty or field supervisors to "friend" you while you are in the program. This puts faculty and yourself in an awkward situation with personal information about each other. If you mutually decided to do this after the program, this is your personal choice.

8. If there is any question or you are unsure of something regarding social networking, call your direct FW educator or Academic Fieldwork Coordinator for advice.

9. If you are attached to your cell phone and have to look at it constantly, it is advised you leave your cell phone in your car or in the office so you are not tempted to pull it out while you are with a patient, caregivers, your FWED, etc.

10. Consider what you post on any social networking site. Many potential employers go to these sites to see what you have posted and often determine if they are interested in having you as an employee. Consider googling your name to discover what is in cyberspace that others can see about you.

I_____ have read and agree to follow the above Social

Networking Policy on _____ (date).

_____ _____
AFWC SIGNATURE DATE

WALTERS STATE COMMUNITY COLLEGE
DIVISION OF HEALTH PROGRAMS
HEALTH INSURANCE CONSENT FORM

I,_____am enrolled in Health Programs at Walters State Community College (WSCC).

Place initials beside each section.

_____I. Clinical Affiliates may require students carry health insurance. I must adhere to the requirements of the Clinical Affiliates I am assigned to as a Walters State Clinical Student.

_____II. I must be able to show proof of personal health insurance coverage should a Clinical Affiliate request to see it.

_____III. I am responsible for all costs incurred related to health insurance, health problems, or accidents that may occur while functioning in the role of a student.

_____IV. If I cannot meet the requirements of Clinical Affiliates to participate in the clinical portion of the course(s) in which I am currently enrolled, I will not be able to continue in the course(s).

_____V. I understand that should my insurance status change for any reason, I will notify the Health Programs Division immediately.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in WSCC Health Programs. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

This in no way negates or limits policies and procedures in program specific material.

_____ _____
Student's Signature Date

_____
Student's Name (Print)

_____ _____
AFWC Signature Date

Student Background Investigation and Drug Screen Instructions

Student Name (printed):_____ Student ID Number: _____

Student Signature: _____ Date: _____

By my signature above, I acknowledge that I have received and read the information provided regarding the background check and drug screen. I am aware that if I have questions about the material herein, it is my responsibility to seek assistance from any Occupational Therapist Assistant Program faculty member or Program Director.

A background investigation and drug screen are requirements of the clinical agencies for your program of study. Failure to complete these requirements will prevent you from completing clinical rotations.

STEP 1: What to do to get a Background Investigation?

Below are step-by-step instructions for accessing Application Station: Student Edition to authorize and pay for a background investigation.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. Enter the Code: **WSCCOTA191-CBC** in the Application Station Code field.
3. Click the "SIGN UP" button to create an account.
4. Follow the instructions on the Application Station web site.

Note – please store the username and password created for Application Station in a secure location. This information is needed to enter Application Station in the future which includes obtaining a copy of your background investigation report.

If you encounter issues with the Application Station: Student Edition or have questions regarding the site, please contact Truescreen's Help Desk at 888-276-8518, ext. 2006 or itsupport@truescreen.com.

Background Investigations are completed, on average, within 3 to 5 business days. Once completed, you will receive an email from Truescreen, studentedition@truescreen.com. Follow the link in the email to access Application Station: Student Edition to view the report. To access the site use the same username and password created at the time you submitted your background check. Application Station includes instructions for disputing information included in the background check should you feel anything is incorrect.

The initial background investigation consists of the search components listed below. All records are searched by primary name and all AKAs, a student's primary address, and all addresses lived within the past seven years.

- Social Security Number Validation and Verification
- County Criminal Records Search – all counties of residence lived in the past 7 years
- National Sexual Offender Registry Search
- Professional Licensing
- SanctionsBase Search (includes TN Abuse Registry)
- OIG/SAM

The cost of the Background Investigation is $36.25. Truescreen accepts credit cards and PayPal. Payment is collected within ApplicationStation: Student Edition.

STEP 2: What to do to get a Drug Screen?

Below are step-by-step instructions for accessing Application Station: Student Edition to authorize and pay for a drug screen, as well as locate a specimen collection site. Drug screen collection facilities are listed on the final page of Application Station: Student Edition.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. Enter the Code: **WSCCOTA191-DS** in the Application Station Code field.
3. Click the "SIGN UP" button to create an account.
4. Follow the instructions on the Application Station web site.

Note – you can use the same username and password created for the background investigation. Please store the username and password created for Application Station in a secure location. This information is needed to enter Application Station in the future which includes obtaining a copy of your drug screen report.

If you encounter issues with the Application Station: Student Edition or have questions regarding the site, please contact Truescreen's Help Desk at 888-276-8518, ext. 2006 or itsupport@truescreen.com.

If none of the collection sites listed are convenient (within 30 minute drive), please contact Truescreen's Occupational Health Screening Department (i.e. TriTrack and Scheduling Hotline) for assistance with locating an alternate location; phone number 800-803-7859.

If the initial drug screen is reported as positive/non-negative, you will receive a call from Truescreen's Medical Review Officer (MRO). The MRO will obtain medical proof as to why you test positive. If you are taking any form of prescription medicine, it is wise to proactively proof from your physician to be provided to the MRO when contacted. This will speed up the process of reporting drug test results.

All drug screens conducted for Walters State Community College are 15-panel and tests for:

- Amphetamines
- Barbiturates
- Benzodiazepines
- Cocaine Metabolites
- Fentanyl
- Marijuana
- Meperidine
- Methadone
- Opiates
- Oxycodone
- Pentazocine
- Phencyclidine
- 6AM
- MDMA
- Buprenorphine

You will receive an email from Truescreen, studentedition@truescreen.com, once drug test results are available. Follow the link in the email to access Application Station: Student Edition to view the report.

The cost of the Drug Screen is $54.00. Truescreen accepts credit cards and PayPal. Payment is collected within ApplicationStation: Student Edition.

If the student receives a "REVIEW" (red X) or "FAIL" (solid red square) on either the background investigation or drug screen, the Occupational Therapist Assistant Program Director will communicate this information to the Clinical Education Director at the respective clinical facility. The Clinical Education Director will then determine if the student can enter clinical rotations. The student is to schedule an appointment with the Clinical Education Director at the appropriate facility. During the scheduled appointment, the student applicant will provide the original background check documentation to the Director of Clinical Education for verification and review. The Director of Clinical Education will review the conviction record and determine "clearing/not clearing" of the student applicant based on approved criteria.

If permitted, an electronic copy of the background investigation can be forwarded to the Director of Clinical Education via Report Deliver Manager.

Report Delivery Manager

Report Delivery Manager (RDM) allows students to distribute an electronic copy of your background check and drug screen results to a third party for clinical rotations. RDM can be found in Application Station: Student Edition. Reports are available to students for 36 months. If reports are needed beyond 36 months, students must print a copy to be distributed as needed.

1. Click the link below or paste it into your browser: http://applicationstation.truescreen.com
2. To access the Report Delivery Manager, choose the "Returning user login" option on the right side of the home page and click "Log in."
3. Enter the username and password created at the time of submitting your background investigation and/or drug screen.
4. Click "View Report Delivery Manager" at the bottom of the ApplicationStation code for the program/application you need to deliver. This can be found after you completely log in and provide your ApplicationStation code.
5. A new screen will appear. To authorize a new third party to view a background check, click "Create a New Delivery."
6. Read the "Important Notice", type your name and click "Agree."
7. Supply the third party's contact information: Last Name, First Name and Organization. Report Access Keys are generated, including an ApplicationStation Code and Access PIN.

Truescreen recommends that the student contact the third party and provide the ApplicationStation website address, code and PIN to their contact verbally. This method provides the highest level of security. However, the student can also authorize that an e-mail containing this information be sent to the contact at the clinical facility. If you wish to have an email containing the Access Keys to be sent directly to the clinical facility, follow steps 8 and 9.

8. To authorize an e-mail, locate "Other Delivery Options, Option 2" and click "here to send an email."
9. Provide and confirm the recipient's e-mail address, and then select either Option 1 or Option 2, which determines what information is sent to the recipient via e-mail.

The system provides confirmation that an e-mail has been sent, along with the ApplicationStation Code and Access PIN for future reference.

WALTERS STATE COMMUNITY COLLEGE
Occupational Therapy Assistant
Program CONSENT FORM

I,_____am enrolled in the Occupational Therapist Assistant Program at Walters State Community College (WSCC). I acknowledge receipt and understanding of the Walters State Community College Student Occupational Therapist Assistant Handbook. My signature indicates that I have read and understood this consent and release, and I have signed it voluntarily in consideration of enrollment in the Occupational Therapist Assistant Program at Walters State Community College.

Place initials beside each section

I._____ I have obtained a copy of the WSCC Occupational Therapist Assistant Program Student and Clinical Education Handbooks and online catalog and agree to abide by the policies within. OTA Student and Clinical Education Handbook is available online on the OTA website. The Walters State Community College Catalog is available on the Walters State website.

II._____ I hereby give permission for the WSCC Health Programs to release information regarding my malpractice insurance policy, CPR course completion, and the results of my criminal background, and drug screen information to the clinical agency where I am assigned.

III._____ I hereby give permission for a copy of my current Health History and Physical, or other information to be submitted to clinical facilities or their designees. I understand this information will be released only by request of the clinical facility(s).

IV._____ I hereby give my permission for any submitted course material is to be utilized by the faculty for curriculum evaluation and development. I understand that my name will not appear on the copy.

V._____ I give my permission to WSCC to release personal identifiable information to the clinical facilities for the purpose of clinical education.

VI.____ I have read the Standard Precautions Procedure located in the OTA Student Handbook. I agree by my signature to abide by the contents within.

VII.____ I understand that WSCC strongly recommends every student to carry health insurance and that I am responsible for all costs incurred related to health problems or accidents should these occur while functioning in the role of a student.

VIII.____ I hereby give my permission for the Walters State Community College Occupational Therapist Assistant Program to use (and/or reproduce) my image (photograph, video, etc.) for educational purposes only. The images that I allow relate directly to activities of the OTA Program and will be used only to enhance my learning, the learning of other students, and assessment by faculty, curriculum evaluation/development, and publicity. These images will be retained by Walters State Community College.

I hereby acknowledge by my signature below that I accept and understand the policies with which I must comply throughout my enrollment in the WSCC Occupational Therapist Assistant Program. I further acknowledge that I will comply with all policies outlined in this document and policies that are made known to me in other WSCC or clinical affiliate site documentation, including handbooks and syllabi. I acknowledge that I affirmatively agree to each of the provisions of this document as indicated by my initials beside each section of this Consent Form.

_____ _____
Student's Signature Date

_____
Student's Name (Print)

_____ _____
AFWC Signature Date

WALTERS STATE COMMUNITY COLLEGE
DIVISON OF HEALTH PROGRAMS

AGREEMENT FOR STUDENTS IN THE HEALTH PROGRAMS AT WSCC REGARDING STUDENT CONDUCT

The WSCC Health Program student agrees to conduct himself or herself in a professional, honorable, and ethical manner.

I. Professional Behaviors
   - A. Actively participates and accepts responsibility for learning
   - B. Effectively communicates
   - C. Demonstrates dependability
   - D. Demonstrates appropriate adaptability
   - E. Appropriately utilizes resources
   - F. Maintains acceptable level of personal appearance
   - G. Uphold Core Values of Professionalism in Occupational Therapy
     (See OTA Student Handbook Appendix)

II. Honorable and Ethical Behaviors
   - A. Demonstrates accountability for all actions
   - B. Demonstrates respect in all situations
   - C. Demonstrates ethical behavior in all situations
   - D. Abide by the Standards of Ethical Conduct for the Occupational Therapist Assistant
     (See OTA Student Handbook Appendix)

By accepting admission to the health programs as WSCC you are voluntarily agreeing to abide by the Student Conduct Agreement.

This in no way negates or limits policies and procedures in program specific material.

Signature of student_____ **Date** _____

Signature of AFWC_____ **Date** _____

WALTERS STATE COMMUNITY COLLEGE
OCCUPATIONAL THERAPY ASSISTANT PROGRAM
Student Confidentiality/Non-Disclosure Acknowledgement

Student_____

As a student in the OTA Program, I understand that I will be working with medical records and confidential information for patients at various healthcare facilities.

I understand that healthcare facilities remind their employees and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue.

The healthcare facility/facilities that I may be assigned to have a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my assignment at any healthcare facility that is an Affiliate of Walters State Community College, I may come into possession of confidential patient information.

Medical records are confidential, legal, personal documents. The contents of individual patient's medical records are to be kept strictly confidential. As a condition of my assignment, I hereby agree that, unless directed by my instructor, I will not at any time during or after my assignment with the Affiliate healthcare facility disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other that as necessary in the course of my assignment. When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved in the patient's care.

Occupational Therapist Assistant students must treat as confidential all information relating to the personal, financial, and business affairs of the healthcare facility and its employees.

I pledge not to discuss the contents of any patient's medical record or any confidential information which comes to my knowledge except when such discussion is relative to the learning experience. I further agree to abide by the Health Insurance Portability and Accountability Act (HIPAA) guidelines in effect at the individual healthcare facility to which I am assigned. I understand that a violation of confidentiality in any of the above-described areas may be grounds for dismissal from the Occupational Therapist Assistant Program. I also understand that I may be in violation of the regulations of the Health Insurance Portability and Accountability Act of 1996 as effective April 14, 2003.

_____

Student's signature Date

_____

AFWC Signature Date

WALTERS STATE COMMUNITY COLLEGE
AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION AND ACKNOWLEDGEMENT

I, _____ hereby authorize Walters State Community College, ("Institution") including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of my background check and credential check(s) as these terms are generically used by background check agencies, hospitals, clinics and similar medical treatment facilities, to disclose the same to such facilities and the appropriate institutional administrators and faculty providing clinical instruction at such facilities, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic, or similar medical treatment facility may exclude me from clinical placement on the basis of a background check. I further understand that if I am excluded from clinical placement, I will not be able to meet course requirements and/or the requirements for graduation. I release the Institution and its agents and employees from any and all liability in connection with any exclusion that results from information contained in a background check.

Any hospital, clinic or similar medical treatment facility to which I am assigned may be required by the Joint Commission on Accreditation of Healthcare Organizations' policy to conduct an annual compliance audit of five percent (5%) or a minimum of thirty (30) background investigation files. I agree that, upon request from a hospital, clinic or similar medical treatment facility to which I am assigned, I will provide the results of my background check to be used for audit purposes only.

_____
Student Signature

_____
Print Name

_____
Date

_____
AFWC Signature

_____
Date

Consent to Drug/Alcohol Testing Statement
of Acknowledgment and Understanding
Release of Liability

I,_____am enrolled in the Allied Health and/or Nursing program at Walters State Community College. I acknowledge receipt and understanding of the institutional policy with regard to drug and alcohol testing, and the potential disciplinary sanctions which may be imposed for violation of such policy as stated in the Walters State Community College Student Handbook.

I understand the purpose of this policy is to provide a safe working and learning environment for patients, students, clinical and institutional staff; and property. Accordingly, I understand that prior to participation in the clinical experience, I may be required to undergo drug/alcohol testing of my blood or urine. I further understand that I am also subject to testing based on reasonable suspicion that I am using or am under the influence of drugs or alcohol.

I acknowledge and understand the intention to test for drugs and/or alcohol and agree to be bound by this policy. I hereby consent to such testing and understand that refusal to submit to testing or a positive result of the testing may affect my ability to participate in a clinical experience, and may also result in disciplinary action up to and including dismissal from Walters State Community College.

If I am a licensed health profession, I understand that the state licensing agency will be contacted if I refuse to submit to testing or if my test result is positive. Full reinstatement of my license would be required for unrestricted return to the Walters State Community College Allied Health and/or Nursing Program.

My signature below indicates that:

1.) I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.
2.) I authorize the release of all information and records, including test results relating to the screening or testing of my blood/urine specimen, to the Office of Student Affairs, the Dean of the Allied Health and/or Director of OTA Program, and others deemed to have a need to know.
3.) I understand that I am subject to the terms of the general regulation on student conduct and disciplinary sanctions of Walters State Community College, and the Drug-Free Campus/Workplace Policy of Walters State Community College, as well as, federal, state and local laws regarding drugs and alcohol.
4.) I hereby release and agree to hold harmless Walters State Community College and the Tennessee Board of Regents, their officers, employees and agents from any and all action, claim, demand, damages, or costs arising from such test(s), in connection with, but not limited to, the testing procedure, analysis, the accuracy of the analysis, and the disclosure of the results.

My signature indicates that I have read and understand this consent and release, and that I have signed it voluntarily in consideration of enrollment in the Allied Health and/or OTA Program at Walters State Community College.

_____ _____
Student's Signature Date

_____ _____
AFWC's Signature Date

Emergency Contact Form

Date

Last Name

First Name
MI

Home Address

City State Zip Code

Home Phone Work Phone

Date of Birth

Emergency Contacts

Primary Emergency Contact

Home Phone Work Phone

Address

City, ST Zip Code

Secondary Emergency Contact

Home Phone Work Phone

Address

City, ST Zip Code

Medical Information

Insurance Provider

Policy Number

Insurance Member ID

Allergies/Special Health Considerations? Yes / No
If yes, please list all allergies.

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by authorizes emergency personnel. Please be honest when completing all pertinent information.

Student's Signature Date

AFWC's Signature Date

Walters State Community College

OCCUPATIONAL THERAPY ASSISTANT PROGRAM CONTRACT

Date of Enrollment: _____
Student's Name: _____
W Number: _____

Student Initial	Program Policies
	I understand that I am responsible for having read the following materials: • OTA Policies as posted on the OTA webpage • Course Policies • WSCC Student Handbook • WSCC Catalog I am responsible for adhering to all policies and guidelines as stated and for keeping abreast of any changes made to these documents during my enrollment in the OTA Program at WSCC.
	▸ I understand that for some clinical placements (Fieldwork I and II) I may have to have a current health record containing either a negative TB skin test or a current chest x-ray report, and satisfactory evidence that all required immunizations have been completed. ▸ I understand that other immunizations and health records may be required by a fieldwork site. ▸ I understand it is my responsibility to provide all information as outlined by the Program. ▸ I understand that I am responsible for all costs associated with obtaining required immunizations and information. ▸ I understand that if I do not provide this information, as required, that I may not be able to participate in Level I or Level II as scheduled. Failure to provide this information could impact my course schedule.
	• I understand that I must have a completed Criminal Background Check and Drug Screen on file with the Academic Fieldwork Coordinator • The Background Check and Drug Screen must be completed per the posted guidelines. • I understand that the information from the Background Check and Drug Screen may be requested by a fieldwork site. I may be required to give access to that information, provide that information, and/or understand that the school may provide that information to the fieldwork site on my behalf. • I understand that participation at the Fieldwork site is at the discretion of the site, and if I have a negative criminal history or negative Drug Screen I may not be able to participate in/complete a fieldwork experience. • I understand that if I have a negative criminal history or drug screen history the Program is not obligated to provide a fieldwork placement and that I may not be able to complete the Program.
	I understand that I must have submitted all required Health screening and proof of current Health Insurance. I understand that maintaining current Health Insurance, and providing proof of such, is a requirement of Program participation.
	I understand that I must purchase liability insurance before I can participate in a Fieldwork I placement in the Fall Semester of my first year, and again before the Fall Semester of the second year. I understand that I must provide current proof of liability to the OTA program at the beginning of each fall semester. I understand that coverage must be purchased according to school requirements (provided elsewhere). I understand that individual fieldwork sites may request additional coverage, and it will be my responsibility to purchase the additional coverage in a timely manner.
	• Level I and II Fieldwork experiences provided as a courtesy to students by fieldwork sites. I understand that as a student I am to be on time for all assigned appointments. • I understand that I am to make every effort to be prepared for each day at the site. • I understand that I may have to prepare evenings and weekends in order to meet the needs of my clients. • I understand that my supervisors first responsibility is to provide good, quality care to the patients we serve, and I will not make demands on time or create an environment where patient care is/could be compromised.

	• Failure to comply may prevent me from further Level I Fieldwork participation and failure of the related OTA course.
	I understand that I must pass all Fieldwork Level I components of OTA 1140, OTA 1260, and OTA 2160 to receive a passing grade in these courses.
	• I understand that being absent from the OTA classes is only acceptable due to sickness or emergency situations, such as illness of a child or family member. • Excessive absences require a medical excuse and may result in withdrawal or dismissal from the program. • I understand that repeatedly coming to class late is not acceptable and that the OTA faculty have the right to refuse the student entrance into class after the class has begun. • I understand that the attendance policy is outlined in the Course Policies for each OTA class.
	I understand that I may have to incur some printing and supply expenses in some of my OTA course work. This may be in the form of a lab fee, or it may be that I will have to purchase my own supplies.
	The following grading scale is used for all OTA Program classes: ▸ 93 – 100 = A ▸ 85 – 92 = B ▸ 75 – 84 = C ▸ Below 75 = failing
	Performance competencies are an integral part of the OTA curriculum. Students must be able to demonstrate the ability to perform a specific skill, and demonstrate effective clinical reasoning to apply that skill in the appropriate manner given a clinical scenario. Students must earn a grade of "75" or above on each competency to pass the course.
	I understand that I must have a C or better in all General Education courses, and a C or better in all my OTA courses in order to graduate from the OTA Program. General Education course grading scales are determined by the individual course instructor
	I understand that all OTA and General Education coursework must be completed with a grade of C or better before I will allowed to participate in Level II Fieldwork placement.
	I understand that cheating is not tolerated in the OTA Program. Students found to be cheating may be dismissed from the Program. Plagiarized work will not be accepted for a grade, and disciplinary action will be initiated. Turning in work for a grade that was not researched and prepared by me will not be accepted. Lying to, or purposely misleading an instructor will result in the student being asked to withdraw. Refer to WSCC policy on cheating and information in "Course Policies".
	In order to provide the best possible experience for students participating in fieldwork activities, the OT Program faculty has the right to provide student information (academic, personal, attitude, character) to fieldwork supervisors.
	I understand that while representing the OTA Program or OTA Organization, I must exhibit professional behavior at all times. Failure to exhibit professional behavior could result in termination from the OTA Program.
	I understand that the OTA Organization activities are part of the OTA Program, and participation in meetings and activities is expected. Those activities which expand the classroom objectives are required.
	I understand that WSCC has a "no children in the classroom" policy. This also applies to clinical sites. There are occasional assignments in which children are allowed. Those assignments will be outlined by course.
	Phones must be stored away and set on vibrate during class time. Students must communicate with the instructor, prior to class, if for any reason a phone must be kept available. Students will follow a fieldwork sites policy regarding cell phone use.
	I understand that I will be evaluated on Professional Behavior by the faculty, and satisfactory performance is mandatory in order to be a candidate for Level II Fieldwork. If a student has an unsatisfactory grade on the Professional Behavior rating form at the end of Fall Semester prior to Level I Fieldwork, the student will not receive a Level II Fieldwork placement until they earn a satisfactory in all behavior areas
	I understand that as a student enrolled in the Occupational Therapy Assistant Program at Walters State Community College as a part of my educational responsibilities that I may have to leave Walters, Tennessee to fulfill my Fieldwork Training in Occupational Therapy (OTA 2210 & OTA 2220). I understand that I will be responsible for expenses.

	Students must successfully complete two, eight week Level II Fieldwork experiences to graduate from the WSCC OTA Program. Successful completion is defined as the student receiving a passing score on the AOTA Fieldwork Performance Evaluation of the OTA Student. ▸ If a student fails one Level II Fieldwork experience, the student will review performance with the Level II Fieldwork Coordinator. ▸ Each student must develop a plan for remediation that is accepted by the OTA Faculty. This plan must be deemed appropriate and all steps of plan must be completed prior to initiation of a placement search for another affiliation. ▸ If a student fails two fieldwork experiences, they fail the program and are not granted a degree
	I understand that it is not in my interest to be employed during Fieldwork II (OTA 2210 and OTA 2220). Working during the first semester of the second year is discouraged. If I have concerns about this, I will discuss this with the OTA Program Director.
	I understand that the OTA Program is preparing me for a professional career. I understand that I am expected to conduct myself in a professional manner in class as well as on fieldwork. I understand that I am to treat my classmates and my instructors with respect. Failure to conduct myself in a professional manner (including language, dress, and personal actions towards others) may result in dismissal from the Program.
	I understand that if I have concerns regarding my coursework, it is my responsibility to contact my instructor in a timely manner to address those concerns. Failure to address questions and concerns in a timely manner may mean that the instructor is not able to provide answers or support as requested.
	I understand that my instructors provide advice, suggestions and comments that are in my best interest. I understand that instructors must make decisions that are in the best interest of the group as a whole. While individual accommodation may be possible on occasion, it may not be possible all of the time. I will respect the decision of the instructor in these situations.

I have read and understand the above statements and realize the implications and regulations as so stated.

Student's Signature: _____ Date: _____

AFWC's Signature: _____ Date: _____

Walters State Community College does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities.

Walters State Community College
Health Programs
Occupational Therapy Assistant Program

REQUIREMENT TO PARTICIPATE AS THE ROLE OF "PATIENT"

I understand that as part of the laboratory/clinical experience in the Occupational Therapist Assistant Program courses, I will be required to participate as the role of "patient".

As the "patient", I will be required to act as a human subject by: allowing instructors/fellow students to demonstrate/practice examination/assessment on me; demonstrate/practice therapeutic skills with me; apply various therapeutic modalities on me; and instruct me in various therapeutic exercises. I understand that I will be given equal opportunity to practice the same techniques on fellow students as they participate in the role of "patient".

In conjunction with my above role as "patient", I hereby certify that it is my responsibility to disclose any medical or physical condition that would prohibit me from participating in the above role of patient, including any or all indications, precautions, or contraindications to any modality, exercise, or activity. I understand that I will be informed of these indications, precautions, and contraindications during the curriculum prior to assuming the role of "patient" for any modality, exercise, or activity. If I am diagnosed with any medical or physical condition or become pregnant during the course of the curriculum, I will notify my instructor(s) immediately if I should not participate in a particular activity. I understand that all medical information will be kept confidential.

Student Name _____
(Please print)

Student Signature _____ Date _____

AFWC Signature _____ Date _____