CLINICAL PASSPORT UPDATE

2nd YEAR PTA STUDENTS FALL 2019

Please read carefully.

		Deadlines
Step 1	**Medical Information – Check expiration dates on all medical info!** **Your TB skin test must be renewed annually. If yours has expired or will expire at the beginning of the semester, please have a new test done.** Submit date of test, result of test, signature of health care provider (HCP) at orientation. Chest x-ray is required if TB skin test is positive. If you have any other immunization records to submit or update, please bring them on 8/28/19.	**August 28**
Step 2	**Insurance Forms** Go to: HPSO.COM (1.800.982.9291) Click on Get a Quote, follow application guidelines. Make coverage effective first day of class. Bring a copy to class.	**Proof of coverage August 28**
Step 3	**CPR** – If your CPR has expired, submit a copy of your current CPR course completion card. (front and back). CPR certification **must** be **American Heart Association Healthcare Provider BLS**.	**August 28**
Step 4	**Health Insurance Consent Form** – Initial beside each statement, sign, and date. Submit copy of health insurance card if applicable.	**August 28**
Step 5	The flu shot is required during the 3rd semester of the PTA Program. Submit proof of the flu shot to DCE by 9/10/19	**Submit by September 10**
Step 6	**Drug Screen** -Some clinical agencies require drug screens. Drug screens will be ordered through Truescreen A Truescreen chain of custody form must be picked up from a PTA faculty member prior to your drug screen. Instructions will be discussed during the first week of PTA class.	**Submit by September 10**
Step 7	**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. **The cost will be approximately $31.25. Instructions for ordering your background check will be provided to you**.	**Submit September 10**
Step 8	**MAKE A COPY OF ALL FORMS FOR YOUR FILES FOR FUTURE REFERENCE!** Once submitted, your files will ***NOT*** be returned to you. Professional development implies that **YOU** maintain your personal records of all forms.	**Make copies for yourself!**

Questions? Call 423-585-6968.

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
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)