

INFORMATION PACKET
NEW PTA STUDENT GREENEVILLE ADMITS FALL 2019
Questions? Call 423-585-6870

Please read carefully (8 pages) All required documents must be submitted by the deadlines indicated below.

	Complete all steps.	DEADLINES
Step 1	<p>Physical Form (Cream Sheet) -- Make your appointment date as soon as possible. <u>Dates are important</u> – Check the boxes when completed! Be SURE your Health Care Provider has documented in <u>all</u> the spaces.</p> <p><input type="checkbox"/> Complete <u>Physical form</u> on both sides (cream sheet) side 1 completed by student, side 2 completed by Health Care Provider</p> <p><input type="checkbox"/> 2-Step TB Skin Test with placement dates, reading dates, and results. First test is placed, read with 48-72 hours. Student returns 1-3 weeks later 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.</p> <p><input type="checkbox"/> Tetanus (TDAP) with date (must have been received within previous 10 years)</p> <p><input type="checkbox"/> (2) MMRs with date or rubella AND rubeola AND mumps titers that indicate immunity</p> <p><input type="checkbox"/> (3) Hepatitis B vaccine dates or Hepatitis B titer that indicates immunity</p> <p><input type="checkbox"/> (2)Varicella vaccine dates or Varicella titer that indicates immunity</p> <p><input type="checkbox"/> current season flu shot (student will submit flu shot annually as seasonal flu shot becomes available)</p> <p><i>If titers are drawn to show immunity, <u>titer report listing results and immunity reference ranges</u> must be submitted with the physical form. Contraindications for MMR, Hep B, or Varicella must be documented by Healthcare Provider.</i></p> <p>***STUDENT MUST TURN IN ORIGINAL CREAM COLORED 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.</p>	<p>Student makes her/his appt.</p> <p>Health Care Provider must complete physical form.</p> <p>Submit at Orientation August 23</p>
Step 2	<p>Certificate of Professional Liability Insurance Go to: WWW.HPSO.COM (1.800.982-9491) – Click on Get a Quote, follow application guidelines. Make coverage effective for scheduled orientation date. Certificate of Professional Liability Insurance will be emailed to you after purchase. Please submit the certificate showing proof of professional liability insurance coverage at the date of your assigned PTA student orientation.</p>	<p>Submit August 23</p>
Step 3	<p>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.</p>	<p>TBA</p>
Step 4	<p>CPR: Submit copy of front/back of CPR Card. Completion card <u>must</u> 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 course.</p>	<p>Submit August 23</p>
Step 5	<p>PTA Student and Clinical Education Handbook: Download and save the 2019-2020 PTA Student and Clinical Education Handbooks from the PTA website. You do NOT need to print the handbooks, unless you choose to.</p>	<p>Bring to Orientation August 23</p>
Step 6	<p>Forms: Please complete and/or sign: Health Insurance Consent Form, Consent Form, Student Conduct Form, HIPPA (Privacy agreement), Criminal Background form, and Drug/Alcohol Abuse Policy, Liability Release Form, Requirement to Participate as the Role of “Patient” form (a portion of this info is in your handbook that you are required to read) All consent forms are valid for 2 calendar years from date signed unless student is readmitted.</p>	<p>Submit August 23</p>
Step 7	<p>Criminal Background Check: A <u>Truescreen</u> 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 at orientation.</p>	<p>September 9</p>
Step 8	<p>Drug Screen: Most 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. Chain of custody forms will be handed out the day of orientation along with instructions.</p>	<p>TBA</p>
Step 9	<p>Photo: Two (2) photos of student with signature on back. Picture should be of the student only (no groups of people, please), no bigger than 3x5, and appropriate. Inappropriate pictures will not be accepted.</p>	<p>August 23</p>
Step 10	<p>MAKE A COPY OF ALL DOCUMENTATION BEFORE SUBMITTING! Professional development implies that <u>YOU</u> maintain your personal records of the above. Documentation submitted will not be returned for any reason.</p>	<p>Make copies for yourself</p>
Step 11	<p>Completed information packets must be submitted during course orientation.</p>	<p>August 23</p>

Criminal Background checks are a requirement for training at all 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 cost of the criminal background check will average \$90.00. 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.

** 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*

To assist us in allowing others into the program, please notify us if your plans change. Call 423-585-6968.

**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)

WALTERS STATE COMMUNITY COLLEGE
Physical Therapist Assistant Program
CONSENT FORM

I, _____ am enrolled in the Physical Therapist Assistant Program at Walters State Community College (WSCC). I acknowledge receipt and understanding of the Walters State Community College Student Physical 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 Physical Therapist Assistant Program at Walters State Community College.

Place initials beside each section

- I. _____ I have obtained a copy of the WSCC Physical Therapist Assistant Program Student and Clinical Education Handbooks and online catalog and agree to abide by the policies within. PTA Student and Clinical Education Handbook is available online on the PTA 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 PTA 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 Physical 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 PTA 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 Physical 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)

**WALTERS STATE
COMMUNITY COLLEGE
DIVISION 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 Physical Therapy
(See PTA 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 Physical Therapist Assistant
(See PTA 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** _____

**WALTERS STATE COMMUNITY
COLLEGE PHYSICAL THERAPIST
ASSISTANT PROGRAM
Student Confidentiality/Non-Disclosure Acknowledgement**

Student _____

As a student in the PTA 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 than 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.

Physical 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 Physical 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

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 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

**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 results are 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:

I consent to drug/alcohol testing as required by clinical agencies or as directed by the Office of Student Affairs.

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 Director of the Allied Health and/or Nursing Program, and others deemed to have a need to know.

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.

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 indicated 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 Nursing Program at Walters State Community College.

Student's Signature

Date

Walters State Community College
Health Programs Division
Physical Therapist Assistant Program

REQUIREMENT TO PARTICIPATE AS THE ROLE OF "PATIENT"

I understand that as part of the laboratory/clinical experience in the Physical 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.

Name _____
(Please print)

Signature _____

Date _____