MILWAUKEE AREA Technical College

Surgical Technology

Petition Requirements & Forms

All MATC Healthcare Pathway students are required to complete criminal background check, drug testing and health requirements* **AFTER** being selected** through the petition process for their program. After being selected to continue the petition process, you will need to complete additional steps before being fully admitted to your program.

Once you have been selected to move forward in the petition process, you must complete a mandatory orientation where instructions for completing these requirements will be provided. The forms below will be used to complete the program requirements.

***** The cost of the criminal background check, drug testing, health examination and immunizations are your responsibility. You may be able to obtain health care services at your local Health Department or you may call IMPACT@ 1-866-211-3380 for a list of clinics in your area.

******Please note that being selected through the petition process, does not guarantee full admission to your program.

DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE!

If you have any questions about uploading forms, call the **MATC Petition Office at 414-297-6088** or contact CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com

HEALTH REQUIREMENTS (Forms attached for your use)

(1) Physical Examination

(2) Measles, Mumps and Rubella (MMR) Vaccination

(3) Varicella (Chicken Pox) Vaccination

(4) Tuberculosis Test

(5) Tetanus Vaccination

(6) Hepatitis B Vaccination

(7) Handbook Acknowledgment

(8) Liability Release

(9) CPR Certification

(10) Essential Functions Form (upload this page only)

(11) Influenza (Flu) Vaccination

(12) Health Insurance Portability and Accountability Act (HIPAA) Acknowledgment

(13) Drug Test Verification Form

(14) Criminal Background (CBC) and Self-Disclosure (BID) Verification Form

(15) Ocular History and Medical Laser Surveillance (Eye Exam) Form

(16) Covid-19 Vaccination - Proof of Completion - Upload a copy of your Wisconsin Immunization Record (WIR) or Electronic Health Record (EHR)

OTHER

☐ **Criminal Background Check (Refer to castlebranch.com)**
Note: *You must disclose* ***everything*** *that is part of your record on the self-disclosure form (BID), regardless of the outcome. All MATC clinical affiliates reserve the right to deny student placement at their facilities. If placement is denied, you will not be able to complete or graduate from your program.*

☐ **Drug Testing (Refer to castlebranch.com)**
Note: *You must upload the drug test verification form in your health requirements profile.*

MILWAUKEE AREA Technical College

Physical Examination
(1)

VERIFICATION OF STUDENTS GOOD HEALTH
(Only Physician, Physician Assistant, or Nurse Practitioner, to Complete the Following:

I have examined ____ and certify that she/he is in good physical and mental health.
Student's Name

On letterhead stationery, please list any physical limitations or other disabilities which would limit this individual's capacity to perform the essential functions of this profession. (See attached)

____ ____
Physicians, Physician Assistant or Nurse Practitioner SIGNATURE & Medical Title *Date*

Print Professional's Name: _______________________________________ OfficeTelephone #_________________________

Address: ___________________________________City:______________________State:___________Zip:______________

A full exam is on file at: ____

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: _________________________ ***Signature***:_______________________________ ***ID #:*** _______________

MILWAUKEE AREA Technical College

Measles, Mumps and Rubella (MMR) Vaccination (2)

Proof of at least two MMR's at least 30 days apart or blood test evidence of rubella and measles immunity. A copy of the titer lab results must be attached if a blood test is performed.

1) MMR Date: ________________ Authorized Signature & Medical Title: ______________________________

2) MMR Date: ________________ Authorized Signature & Medical Title: ______________________________

OR

Rubella Titer ____________ Date: __________ Authorized Signature & Medical Title: ______________________________

AND

Rubeola Titer ____________ Date: __________ Authorized Signature & Medical Title: ______________________________

****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: ________________________ Signature:_______________________________ ID #: _______________

MILWAUKEE AREA Technical College

Varicella (Chicken Pox) Vaccination
(3)

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have positive blood titer test or documentation of 2 shot vaccinations at least 30 days apart. A copy of the titer lab results must be attached if a blood test is performed.

RESULTS

Has this patient had?

Chicken Pox __________ __________ __________ ______________________________
Yes *No* *Date* *Authorized Signature & Medical Title*

OR

Varicella Vaccine #1 __________ ______________________________
Date *Authorized Signature & Medical Title*

30 Days later #2 __________ ______________________________
Date *Authorized Signature & Medical Title*

OR

Varicella Titer __________ __________ ______________________________
Date *Results* *Authorized Signature & Medical Title*

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: ___________________________ ***Signature:***_____________________________ ***ID #:*** _______________

MILWAUKEE AREA Technical College

Tuberculosis Test
(4)

TWO STEP MANTOUX TUBERCULIN SKIN TEST:

Documentation of a Two Step test must be submitted. Skin tests are good for 1 year. If the 2-step is more than a year old, attach documentation of the past 2-step dates, along with a current annual update.

PROCEDURE:

Step 1:
A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered under the skin on the forearm.
A health care professional must read the results within 48-72 hours. If negative perform step 2. If positive, must follow- up with a chest x-ray.

Step 2:
Repeat the test within 7 to 30 days after the application of the first test using the same strength of PPD.
A health professional must read the results within 48-72 hours. If positive, must follow-up with a chest x-ray.

QUANTIFERON – TB GOLD TEST:

The TB Gold blood draw may be performed in place of skin tests. TB gold blood draws are good for one year **and a copy of the lab report must be attached to the health packet.**

REPORTING RESULTS (2 Step or Chest X-Ray or TB Gold)

1. Step 1 Results

_______________	_______________	_______________________________________	_______________
Date Read	*Results*	*Authorized Signature & Medical Title*	*Date Administered*

2. Step 2 Results

_______________	_______________	_______________________________________	_______________
Date Read	*Results*	*Authorized Signature & Medical Title*	*Date Administered*

Chest X-Ray (if required)

_______________	_______________	_______________________________________	_______________
Date Read	*Results*	*Authorized Signature & Medical Title*	*Date Administered*

TB Gold Titer (if required)

_______________	_______________	_______________________________________	_______________
Date Read	*Results*	*Authorized Signature & Medical Title*	*Date Administered*

Annual Update

_______________	_______________	_______________________________________	_______________
Date Read	*Results*	*Authorized Signature & Medical Title*	*Date Administered*

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: ___________________________ ***Signature***_____________________________ ***ID #:*** ________________

MILWAUKEE AREA Technical College

Tetanus Vaccination
(5)

PROOF OF TETANUS VACCINATION: (Within the last 10 years)

______________________________ ____

Date Authorized Signature & Medical Title

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others***

Student Name: ________________________________ ***Signature:***______________________________ ***ID #:*** ________________

MILWAUKEE AREA Technical College

Hepatitis B Vaccination
(6)

Please read thoroughly and check the appropriate box.

☐ As a student, 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 advised 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 can pursue the vaccination series. I hereby release Milwaukee Area Technical College, its Board Members, and personnel, and any clinical facility at which I train from any liability for any consequences to me or any claims arising out of or related to my decision to be or not to be vaccinated. I hereby agree to indemnify all of the above persons and organizations for any and all claims, including the attorneys' fees and costs, which may be brought against any one of them by anyone claiming to have been injured as a result of any injury which may occur as a result of my decision.

OR

☐ I do not wish to decline the Hepatitis B vaccine. I am currently in the process/or have completed the series. I understand that full immunity requires three doses of vaccine over a nine-month period.

____
Signature of Student *Student ID#* *Date*

____
Print Name

IF HBV given:

1st Dose Date: _____________ ______________________________________
Authorized Medical Signature

2nd Dose Date: ____________ ______________________________________
Authorized Medical Signature

3rd Dose Date: _____________ ______________________________________
Authorized Medical Signature

I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Student Name: _______________________ ***Signature:*** ___________________________ ***ID #:*** _______________

MILWAUKEE AREA Technical College

Handbook Acknowledgement
(7)

Healthcare Pathway Student Handbook
Signature Page

I acknowledge that I am responsible for the contents of the current Healthcare Pathway Student Handbook located on the MATC website under each program page link at:

https://www.matc.edu/course-catalog/healthcare/documents/health_sciences_handbook.pdf

I further agree to abide by the terms and conditions found in the contents of the current Healthcare Pathway Student Handbook.

Student Signature: ____

Student Name: *(Please print)* ____

Student MATC ID Number: ____

Signature Date: ____

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: ___________________________ ***Signature*** ______________________________ ***ID #:*** ________________

MILWAUKEE AREA **Technical College**

Liability Release
(8)

ACCEPTANCE OF RISKS AND RESPONSIBILITYAGREEMENT
AND RELEASE OF LIABILITY

This Acceptance of Risks and Responsibility Agreement and Release of Liability ("Agreement and Release") is executed by: ___________________________________ (please print student first and last name ("Participant") and is issued to Participant is participating in a COLLEGE affiliated Program/Course/Practicum/ Training/Activity ("Activity"). This Activity is more fully described in each of the MATC School of Health Sciences program pages, which have been provided to Participant.

Participant understands that there are certain dangers, hazards, and risks inherent in the Activity. These include, but are not limited to, contact with sharp, contaminated medical instruments, contagious diseases, infectious blood and/or body fluids, electrical instruments, electronic devices or other risks associated with patient care/non-patient care and the particular site.. In certain circumstances, these dangers can include damage/destruction to property, severe bodily injury, and even death.

Participant agrees to exercise reasonable care at all times with respect to Participant's own safety and with respect to the safety of others. Participant agrees to abide by all rules, policies and procedures of the COLLEGE that are set forth in the Code of Conduct found in the COLLEGE's Student Handbook, as well as any additional rules, policies and procedures of the location of the Activity. Participant has no health-related issues that would preclude or restrict participation in the Activity.

Accordingly, Participant, on behalf of him/herself, the Participant's spouse (if applicable), the Participant's heirs, assigns, related individuals and related entities, does hereby WAIVE, RELEASE, AND DISCHARGE the COLLEGE, including its Board of Trustees/Directors, administrators, officers, employees, teachers, agents and insurers, from any and all claims, causes of action, suits, damages, or liabilities sounding in negligence, which the Participant has, shall have, or may have in the future against the COLLEGE arising out of, based on, related to, or connected with, the Participant's enrollment and participation in the Activity. *This release of liability does not, however, apply to any intentional or reckless acts or conduct by the COLLEGE.*

This Agreement and Release shall be governed by the laws of the State of Wisconsin, which shall be the forum for any lawsuits filed under, or incident to, this Agreement and Release.

By signing this document, Participant acknowledges that s/he is fully informed of the contents of this Agreement and Release, and represents that s/he understands it. Participant is not relying on any oral or written representations, statements or inducements, apart from those made in this Agreement and Release.

Participant is at least eighteen (18) years of age, and is competent to sign this document. If Participant is a minor under the age of eighteen (18), the parent and/or guardian acknowledges they are competent to sign this document on behalf of the Participant.

By signing this Agreement and Release, you give up substantial legal rights. Read and understand this entire document before you sign it.

____ _______________________
Participant Date

____ _______________________
Parent/Legal Guardian *(Signature required if Participant is under age 18.)* Date

MILWAUKEE AREA Technical College

CPR Certification
(9)

CPR Verification:

American Heart Association 2-year BLS Healthcare Provider level only.

Sign your CPR card and upload a copy of the FRONT and BACK of the card to castlebranch.com.

MATC offers this CPR course. You can check for course offerings (PHYED-441) and register thru Self Service.

Self-Service link

Other vendors that offer American Heart Association CPR training:

First Aid Plus

Badgerland CPR & First Aid

Advanced Professional Healthcare Education, LLC

Healthline First Aid, LLC

Paratech Community Training Center

Essential Functions Signature Form
(10)
(Upload this page only)

ADA AND ESSENTIAL FUNCTIONS

The Americans with Disabilities Act (ADA) of 1990 (42 USC & 12101. et seq.) and the ADA Amendment Act of 2008, and Section 504 of the Rehabilitation Act of 1973 (29 USC & 794) prohibits discrimination of persons because of her or his disability. In keeping with these laws, Milwaukee Area Technical College makes every effort to insure a quality education for students. To aid in student success, it is important to inform students of the essential functions demanded by a particular occupation. The purpose of this document is to ensure students acknowledge that they have been provided information on the essential functions required for their chosen program. To meet the Essential Functions, information on accommodations is available upon request of the applicant. Please visit the MATC Student Accommodation Services Department.

INSTRUCTIONS

- Click on **YOUR** program link below.
- Read the essential functions required for success in your program.
- If you have read and understood the essential functions for your program, sign and date this form below.

DENTAL PROGRAMS	ALLIED HEALTH PROGRAMS	NURSING PROGRAMS
Dental Assistant	Anesthesia Technology	Nursing Assistant
Dental Assistant Bilingual	Cardiovascular Technology - Echocardiography	Practical Nursing
Dental Hygiene	Cardiovascular Technology – Invasive	Practical Nursing LPN-RN Educational Progression
	Central Service Technician	Registered Nursing
	EKG Technician	
	Health Information Technology	
	Healthcare Services Management	
	Health Unit Coordinator	
	Medical Assistant	
	Medical Coding Specialist	
	Medical Interpreter	
	Medical Laboratory Technician	
	Nutrition and Dietetic Technician	
	Occupational Therapy Assistant	
	Pharmacy Technician	
	Phlebotomy	
	Physical Therapist Assistant	
	Radiography	
	Renal Dialysis Technician	
	Respiratory Therapist	
	Surgical Technology	

COMPLETE, INITIAL AND SIGN

Student Name:____ **Student ID#:** ______________________________

My program is: ____

________**(Initial)** I have read and understand the Essential Functions criteria specific to a student in my program indicated above.
________**(Initial)** I am able to meet the Essential Functions as presented with or without accommodation.
________**(Initial)** I was provided with information concerning accommodations or special service if needed.

Note: The program you indicated above must be the program to which you have applied. Completion of this form verifies that you have read and understand the essential functions required. If you have applied to more than one program, this form must be completed for each of those programs.

____ ________________________
Signature *Date*

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name:___________________________***Signature:***______________________________***ID #:*** _________________

MILWAUKEE AREA Technical College

Influenza (Flu) Vaccination
(11)

As a patient safety initiative, the Healthcare Pathway at MATC requires influenza vaccinations for all students in all health programs.

STUDENT INFORMATION:

Name: ____ **Date of Birth:** ____________________________

Student ID#: ____ **Program:** _______________________________

*****I give permission to release information on the health requirements to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.***

Student Name: _________________________ ***Signature:***_____________________________ ***ID #:*** ________________

For Clinic/Office Use only

Vaccine Information:

Vaccine Administered *(Trade name)*: ______________________________ **Vaccination Date:** _________________________

Vaccine Lot#: _______________________________

Facility Information:

Name of Location: ____

Street Address: ____

City: _______________________ **State:** __________________________ **Zip/Postal Code:** _________________________

Phone Number: ____

Name and Title of Vaccinator *(Please Print):* ____

Signature of Vaccinator: ____________________________________ **Date:** _____________________

Milwaukee Area Technical College

Health Insurance Portability Accountability Act
(HIPAA Training)
(12)

Student is to complete HIPAA Training provided by the North American Learning Institute by following the process below.

HIPAA Training website is https://nalearning.org/hipaa/MATC provided by the North American Learning Institute

- Create an Account
- Training cost is $15
- One hour of minimal training for course. Must preview all pages, cannot skip to post test and will time out if page is left open and no activity recorded. You can stop and start course. Extra Authentication for log in.
- Must score at least 70% or greater for successful completion on Post Test. You can retake Post Test to pass.
- Course can be taken on Desktop, Laptop, Tablet or Phone
- 24/7 Support provided by the North American Learning Institute for Login or technical issues via Text, Phone or Email.
- Customer Service Phone - (407) 906-6254 • Customer Service Email - Help@nalearning.org • Privacy Policy

Upload Successful Course Completion Certificate to CastleBranch Profile

By completing this training, I acknowledge that I agree to abide by the terms and conditions found in the contents of the HIPAA training course.

MILWAUKEE AREA Technical College

Drug Test Verification Form
(13)
(Upload this page only)

Drug Test Verification:

I acknowledge that my drug test **RESULTS** were posted on my CastleBranch, Inc. profile on (date)**:** ____________________________

Note: You must upload the drug test verification form in your health requirements profile after ordering/paying/completion of the drug test itself. This form prompts CastleBranch to enter the next due date for the drug test requirement.

Student Signature: ____

Student Name: *(Please print)* ____

Student MATC ID number: ____

Signature Date: ____

MILWAUKEE AREA **Technical College**

Criminal Background Check (CBC) & Self-Disclosure (BID) Verification Form
(14)
(Upload this page only)

Criminal Background Check (CBC) & Self-Disclosure (BID) Verification Form:

Date of last Criminal Background Check (CBC): ___________________________________

Date of last Self-Disclosure (BID): ____

Note: You complete and upload this CBC-BID verification form in your health requirements profile ***after*** ordering/purchasing and completion of the CBC/BID itself. This form prompts CastleBranch to enter the next due date for the CBC/BID requirement.

Student Signature: ____

Student Name: *(Please print)* ____

Student MATC ID number: ____

Signature Date: ____

Criminal Background Check (CBC) & Self-Disclosure (BID) must be renewed every 2 years.

MILWAUKEE AREA **Technical College**

Ocular History and Medical Laser Surveillance
(15)

Name: ____

Program: ____ **Student ID:** _____________________________________

Have you, or someone in your family ever had any of the following*:*

	Your History		Family History	
• Blackouts	Yes	No	Yes	No
• Diabetes	Yes	No	Yes	No
• Glaucoma	Yes	No	Yes	No
• Headaches	Yes	No	Yes	No
• Heart Problems	Yes	No	Yes	No
• High Blood Pressure	Yes	No	Yes	No
• Previous Eye Problems	Yes	No	Yes	No
• Retinal Problems	Yes	No	Yes	No
• Cataracts	Yes	No	Yes	No
• Thyroid Problems	Yes	No	Yes	No
• Other chronic medical problems	Yes	No	Yes	No

If you answered "yes" to any of the above questions, please clarify: ____
____

Please list all of your current medications (include birth control and vitamins): ________________________________
____

Please list all allergies to food, medication, or the environment: ____
____

Have you ever worked with lasers before? **Yes** **No**

If yes, what type of laser did you work with? ____
Where did you work? ____
What position did you hold? ____

Have you ever been involved in a laser accident? **Yes** **No**
If yes, what were your injuries? ____
____

Do you wear glasses? **Yes** **No**
Do you wear contacts? **Yes** **No**
If yes, for what purpose? ____
Date of most recent eye exam: ____

Student Signature: ____ **Date:** ______________________________

Examine Results: ____ **Date:** ______________________________

Examined By: ____ **Date:** ______________________________

MILWAUKEE AREA Technical College

Ocular History and Medical Laser Surveillance (cont.) (15)

Jaeger:
Near point Acuity
With/without Rx: ____________________
O.D. ____________________
O.S. ____________________
O.U. ____________________

Color Vision:
O.D. _____/9
O.S. _____/9

Distance Visual Acuity:
O.D. ____________________
O.S. ____________________
O.U. ____________________

Time:
Tonometer O.D. _____________
Readings O.S. _____________

Keratometer: O.D. _____________________/___________________
Readings: O.S. _____________________/___________________

Recommended course action:

____
____
____
____

Date: ____

MILWAUKEE AREA Technical College

Covid-19 Vaccination Completion
(16)

Covid-19 Vaccination Completion Process:

Upload a copy of your Wisconsin Immunization Record (WIR) or Electronic Health Record (EHR) to your CastleBranch profile

MILWAUKEE AREA Technical College

INSTRUCTIONS TO STUDENTS

PLEASE NOTE: You MUST make a copy of your completed health forms and retain them.
DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE

SUMMARY OF MATERIALS TO BE COMPLETED

Health Requirements

1.) Physical Examination Form
2.) Measles, Mumps and Rubella (MMR) Vaccination Form
3.) Varicella (Chicken Pox) Vaccination Form
4.) Tuberculosis Test Form
5.) Tetanus Vaccination Form
6.) Hepatitis B Vaccination Form
7.) Handbook Acknowledgment Form
8.) Liability Release Form
9.) CPR Certification (upload front/back of signed/dated Certification)
10.) Essential Functions Form (upload this page only)
11.) Influenza (Flu) Vaccination Form
12.) Health Insurance Portability and Accountability Act (HIPAA) (upload copy of Course Completion Certificate)
13.) Drug Test Verification Form (upload this page only)
14.) CBC/BID Verification Form (upload this page only)
15.) Ocular History and Medical Laser Surveillance (Eye Exam) Form
16.) Covid-19 Vaccination - Proof of Completion

Other

- Criminal Back Check (refer to castlebranch.com)
- Drug Testing (refer to castlebranch.com)

Call or email CastleBranch, Inc. at 888-914-7279 or studentservices@castlebranch.com

or call the MATC Healthcare Pathway at 414-297-6263 or email at healthpathway@matc.edu