Thank you for your interest in Phlebotomy Technician Training at Tunxis Community College. This program is approved by the National Health Career Association. It provides approximately 120 hours of training, including classroom and a hands-on laboratory. Enrollment is limited to 15 students, accepted on a first come, first served basis.

Course content includes: basic aspects of medical terminology; anatomy and physiology; venipuncture; specimen collection procedures; safety and universal precautions; common laboratory tests with clinical significance to body systems and disease processes; and laboratory equipment. Upon successful completion, students are eligible to sit for the National Certification exam that is administered at the college. An optional externship experience is offered at UCONN Health Center after students complete the program (see Associated Costs sheet).

**Program Requirements:**

You must be at least 18 years of age with a high school diploma or GED, and complete the following:

- Fill out the enclosed phlebotomy application Cover Sheet, Questionnaire, Physical Verification form and Health form (health form due by October 10).
- Mail or bring the application, along with the non-refundable $35 administrative fee (credit or debit card, check or money order payable to TCC – no cash please), to Continuing Education, Tunxis Community College, 271 Scott Swamp Road, Farmington, CT 06032.

Your application will be forwarded to the Allied Health Coordinator for consideration. Upon acceptance, you will be notified in writing and given further instructions to complete your enrollment.

Once you are accepted, the tuition must be paid to the College within five business days of notification. Refunds may be obtained only if your written withdrawal is submitted to Continuing Education three business days prior to the first class. Students will not be allowed in to the classroom until they have started the payment plan or paid the full course tuition.

**Health Form:**

Each student accepted to the program must submit a completed health form. See Associated Costs sheet for details. No one can be permitted to participate in the lab portion of the program or externship without this requirement. The original form must be submitted to the Allied Health Coordinator and cannot be faxed. Due October 10. Only submit your health form once it is completed.

For more information, please call the Continuing Education Office at (860) 773-1450.

Students who successfully complete the program are eligible to receive college credit through the Connecticut Credit Assessment Program administered by Charter Oak State College. For information visit [http://www.charteroak.edu/current/programs/creditregistry.cfm](http://www.charteroak.edu/current/programs/creditregistry.cfm)

Please be advised that if you have been convicted of a felony or misdemeanor, you may not be eligible for clinical experiences, internships, externships or certifications associated with certain Allied Health courses or programs. Those with previous convictions may also find it difficult to secure employment within a health care agency or institution.
COSTS ASSOCIATED WITH THE
TUNXIS PHLEBOTOMY TECHNICIAN PROGRAM
FALL 2017

Fees Due Directly to Tunxis Community College:

$35 non-refundable administrative fee
   payable to TCC at the time of registration

$1,850 tuition
   includes malpractice insurance (personal health insurance is recommended in case of injury or exposure)

Payment Plan Option: (includes a $25 installment fee)
$950 – due within five business days of acceptance
$925 – due October 26
You will need to contact or visit the Continuing Education office (Bldg 700)
before setting up your payment plan at the Business Office (Founders Hall).

$249 Optional externship experience at UCONN Health Center

Costs Associated With the Program but Not Payable to TCC:

$115 National Health Career Association Certification Examination fee

$225 (estimated) Textbook/Workbook/Review book and white lab coat
   payable to Follett Bookstore at TCC

$150 (estimated) for uniform: pewter scrub top and pants (no other color)
   sneakers or nursing shoes (not open-toed)
   (Worn at all times during the program)

Funding options may be available through CT Works (WIOA) and the
CT Department of Labor. To see if you qualify, call
New Britain CT Works at 860.827.6200

For a complete listing of services and locations, please visit: ctdol.state.ct.us

This program is not eligible for federal financial aid.
Program Choice (check only one): ☐ DAY ☐ EVENING

Please Note: Evening program not available during summer.

Name_____________________________ Date of Birth_____________________

Home Address______________________________

E-mail Address______________________________

Phone_________________ Work / Cell Phone_________________ SSN_________________

Gender: ☐ Male ☐ Female

Primary Language______________________________

Ethnic/Racial (optional): ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Emergency Contact Name_____________________________ Phone #_________________

Are you a U.S. Citizen? ☐ Yes ☐ No If no, are you an alien who has the legal right to work? ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor? ☐ No ☐ Yes—briefly explain below.

*An arrest record could affect your ability to obtain employment as a CPT.

EDUCATIONAL INFORMATION

High School or GED Certification___________________________________________

(school attended and year graduated or certified)

College or University___________________________________________________________

(school attended, degree and year graduated)

Are you competent in reading comprehension and able to do math computation? ☐ Yes ☐ No If no, please explain.

List employment history below.

Tuition Payment Source ☐ Self ☐ Agency (Agency name, caseworker and phone number required below):

Application Fee Paid By: Check Number ____________ Money Order ________________ ☐ Agency

MasterCard/Visa/Discover: ____________________________ Exp. Date ____________

I understand the refund policy means I must contact the CE office three business days prior to the start of class, and that no refunds will be issued after that time under any circumstances.

The information provided on this registration form is complete and accurate.

Signed_________________________________________________ Date____________________
Name: _________________________________________________________________

Do you have transportation? □ Yes □ No

Tell us about yourself.

What is your primary language? ______________________________________
(Students who are ESL are encouraged to meet with the Allied Health Coordinator to discuss if their language may impede them from completing this course. You should be English proficient.)

List five qualities you possess that would make you a good candidate for the program.

Do you know what being a Phlebotomist entails? Briefly describe.
Why do you want to take this course?

How can Tunxis be assured that you will be committed to the program?

Do you have any physical limitations? If yes, please explain.

Have you ever been arrested? If yes, please explain.

What are your career goals?

How did you hear about this course?

Student Signature: ___________________________ Date: ___________
CERTIFIED PHLEBOTOMY TECHNICIAN PROGRAM
PHYSICAL VERIFICATION FORM

Name of Student_____________________________________________________________________________

Address_____________________________________________________________________________________

City___________________________________________   State___________   Zip Code___________________

Check the appropriate answer.
Please answer as honestly as possible. If yes is checked, please provide a brief explanation.

Allergies? □ Yes □ No

Pregnant? □ Yes □ No

On medication? □ Yes □ No

Please list any medications here:

Mental health concerns? □ Yes □ No

Hearing problems? □ Yes □ No

Back problems? □ Yes □ No

Knee problems? □ Yes □ No

Recent surgeries? □ Yes □ No

Lifting restrictions? □ Yes □ No

(i.e. arthritis, injury, surgeries, etc.)

Latex allergy? □ Yes □ No

If you are pregnant, have any back problems/lifting restrictions, or a medical condition that is being monitored by a physician, a form will be provided by the College that must be completed by your physician along with your signature.

Please list any other conditions that you feel may present a risk for you or that your Instructor should be aware of to protect your well-being and safety.

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Student Signature _____________________________________________ Date:__________________________
HEPATITIS B RISK FORM

I understand that due to my potential exposure to blood, body fluids and other potential infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that because I have either waived or not completed the Hepatitis B vaccination series, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I understand that if I experience an exposure to blood, body fluids or other infectious materials, I must notify my preceptor and/or instructor immediately. I will be directed to the Emergency Department where I will be offered the Hepatitis B virus immune globulin (HBIG), an injection(s). This injection provides temporary passive immunity from Hepatitis B. I will need to continue or start the Hepatitis B vaccination series.

By my signature below I acknowledge understanding that I (the student) am solely responsible for payment of all services, injections, vaccinations and other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have not completed the Hepatitis B vaccination series. I further understand that the College, its employees and clinical sites, will not be responsible for any services, injections, vaccinations or other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have waived or not completed the Hepatitis B vaccination series.

I have received information about Hepatitis B and the risks of exposure to blood, body fluids and other potential infectious materials and my responsibility in reporting any incident of possible exposure.

______________________________________________
Student’s name – please print

______________________________________________
Student’s signature Date
Tunxis Community College
Non-Credit Allied Health Programs

Health Form Requirements Checklist

Please use this checklist to guide you through the process of submitting an accurate and fully-completed health form.

Fill out Page 1

Check which program you’re in

Check_____

Last 4 digits of your Social Security Number

Check_____

Under personal history, if you check yes, please explain.

Check_____

Banner ID# on EVERY PAGE SUBMITTED

Check_____

Page 2 – must be filled out by your physician, PA or APRN

All students are required to provide either proof of immunization or laboratory results of immunity. TITERS chosen for proof of immunization MUST BE POSITIVE and the LABORATORY REPORT MUST ACCOMPANY THE HEALTH FORM.

1. MMR – dates of immunization or blood titer that shows immunity written on health form – attach document to show proof.

Check_____

2. Polio – date(s) of immunization or blood titers that show immunity written on health form - attach document to show proof.

Check_____

3. Chickenpox - dates of immunization, date of illness, or lab report that shows immunity written on the health form – attach document to show proof.

Check_____

4. Tetanus booster – must be within the last 10 years, written on health form, attach proof of injection to the health form.

Check_____

5. Flu vaccine (spring and fall applicants only) - date of vaccine written on the health form.

Check_____

If declination, your health care provider must provide a note.

Attach document to show proof.

6. Hepatitis B series - date(s) of injection or lab report written on the health form.

Check_____

If a student hasn’t received all 3 injections or refuses the series, a Hepatitis B waiver form (included in application packet) must be signed. Attach document to show proof.

Check_____

7. Tuberculin Test/PPD (Mantoux or QF-G) – date given, date read, and results written on the health form. Attach document to show proof.

Check_____

A positive PPD or previous inoculation of BCG, must be accompanied by a chest x-ray with the appropriate follow-up.

Check_____
Health Form Requirements (continued)

Physical Examination- All areas must be filled out in this section. Heart rate and Blood Pressure must be done. Nothing can be deferred. Check _____

A Urinalysis and Hematocrit or Hemoglobin must be documented with a number on the health form. Attach document to show proof. Check _____

Date, Examining MD, PA, or APRN’s signature must be completed along with the address completely filled out and a phone number. Check _____

Submit to the classroom instructor or Allied Health Coordinator Cheryl Conaty, R.N. (Room 6-216). **Please make sure the entire health form is completed before submitting it.**

**Make a copy of your health form for your own personal records before handing it in.**

**Please do not staple forms together; paper clip them or use an envelope.**

Thank You.
Cheryl Conaty, RN
Allied Health Coordinator
Tunxis Community College
Continuing Education and Workforce Development
860-773-1453
**APPLICANT:** Please print. Complete this side.

**EXAMINING PHYSICIAN:** Please print. Complete reverse side ASAP and return to address above.

### Applicant Information

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Social Security #</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Permanent Home Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Marital Status</th>
<th>Date of Birth (month, day, year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Relationship</th>
</tr>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
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### In Case of Emergency

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Relationship</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### Family History

- [ ] CANCER
- [ ] TUBERCULOSIS
- [ ] DIABETES
- [ ] ALLERGY OR ASTHMA
- [ ] EPILEPSY OR CONVULSIONS
- [ ] STROKE
- [ ] HEART DISEASE
- [ ] NERVOUS OR MENTAL ILLNESS
- [ ] MIGRAINE HEADACHES
- [ ] HIGH BLOOD PRESSURE

### Personal History

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>If &quot;YES,&quot; please explain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had any operations and/or significant injuries?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any physical impairment? (eg., paralysis, loss of hearing, vision)</td>
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<tr>
<td>3. Have you had any emotional problems requiring treatment?</td>
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<tr>
<td>4. Do you take any medications regularly?</td>
<td></td>
<td></td>
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<tr>
<td>5. Have you reacted unfavorably to any medication? (eg., penicillin, aspirin)</td>
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<tr>
<td>6. Has your physical activity ever been limited?</td>
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</table>

### Signature(s)

**Signature(s)**

- **Date**
- **Student’s Signature (if under the age of 18, parent or guardian must also sign)**

### Permission to Treat Minor Injury or Illness

- **Date**
- **Parent’s or Guardian’s Signature**

I hereby grant permission to the medical staff of the college to render or secure proper treatment for my daughter, son or ward (named above). It is my understanding that I will be notified in case of any illness or injury of major proportion. In addition, I grant permission to the college physician to hospitalize this student in case of a surgical emergency requiring the administration of anesthesia provided that the physician is unable to communicate with me and that, in his/her judgement, delay might endanger the life of the student.
**IMMUNIZATION HISTORY**

**ALL** students are required to provide proof of either immunization or laboratory results of immunity. **TITERS** chosen for proof of immunization **MUST BE POSITIVE** and the **LABORATORY REPORT MUST ACCOMPANY THIS FORM**.

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
<th>Date/Given</th>
<th>Immune?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEASLES</strong> 1st dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>date/given on or after 1st birthday &amp; after Jan. 1, 1969</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEASLES</strong> 2nd dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>date/given after Jan. 1, 1980</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>MUMPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>date/given on or after 1st birthday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RUBELLA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>date/given on or after 1st birthday</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>POLIO</strong></td>
<td>date(s) of immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VARICELLA</strong> (Chicken Pox)</td>
<td>date(s) of immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Td (TETANUS booster)</strong></td>
<td>date/must have been given within the last 10 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FLU VACCINE</strong> (spring and fall applicants only)</td>
<td>date given</td>
<td>Risk Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HEPATITIS B SERIES</strong></td>
<td>date/1st dose</td>
<td>date/2nd dose</td>
<td>date/3rd dose</td>
<td>initial</td>
</tr>
<tr>
<td><strong>VARICELLA</strong> (Chicken Pox)</td>
<td>date(s) of immunization</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>HEPATITIS B SERIES</strong></td>
<td>date/1st dose</td>
<td>date/2nd dose</td>
<td>date/3rd dose</td>
<td>intial</td>
</tr>
<tr>
<td><strong>VARICELLA</strong> (Chicken Pox)</td>
<td>date(s) of immunization</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**IMPORTANT!**

Attach lab reports or immunization records for everything listed.

**PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>PHYSICAL EXAMINATION</th>
<th>COMMENTS and RECOMMENDATIONS</th>
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</thead>
<tbody>
<tr>
<td><strong>HEIGHT</strong></td>
<td></td>
</tr>
<tr>
<td><strong>WEIGHT</strong></td>
<td></td>
</tr>
<tr>
<td>EYES</td>
<td></td>
</tr>
<tr>
<td>VISION (R)</td>
<td>(L)</td>
</tr>
<tr>
<td>**CORRECTION (R)</td>
<td>(L)</td>
</tr>
<tr>
<td><strong>EARS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>DRUMS</strong></td>
<td><strong>HEARING (R)</strong></td>
</tr>
<tr>
<td><strong>NASOPHARYNX</strong></td>
<td><strong>SEPTUM</strong></td>
</tr>
<tr>
<td><strong>TEETH</strong></td>
<td><strong>OCCLUSION</strong></td>
</tr>
<tr>
<td><strong>TEETH</strong></td>
<td><strong>OCCLUSION</strong></td>
</tr>
<tr>
<td><strong>NECK</strong></td>
<td><strong>CERVICAL NODES</strong></td>
</tr>
<tr>
<td><strong>CHEST</strong></td>
<td><strong>BREASTS</strong></td>
</tr>
<tr>
<td><strong>HEART (Rate)</strong></td>
<td><strong>Rhythm</strong></td>
</tr>
<tr>
<td><strong>ABDOMEN</strong></td>
<td><strong>LIVER</strong></td>
</tr>
<tr>
<td><strong>SKELETAL</strong></td>
<td><strong>SPINE</strong></td>
</tr>
<tr>
<td><strong>CNS</strong></td>
<td><strong>REFLEXES</strong></td>
</tr>
<tr>
<td><strong>LABORATORY</strong></td>
<td><strong>URINALYSIS</strong> (Lab Reports Required)</td>
</tr>
</tbody>
</table>

I believe this student is able to participate in a full academic and clinical program (unless otherwise noted above).

<table>
<thead>
<tr>
<th>DATE</th>
<th>EXAMINING PHYSICIAN’S SIGNATURE</th>
<th>ADDRESS</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M.D.</td>
<td></td>
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