Phlebotomy Technician Program – Fall 2018

<table>
<thead>
<tr>
<th>Day Program:</th>
<th>September 17 – December 4</th>
<th>Mon &amp; Tues</th>
<th>9AM-2PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening Program:</td>
<td>September 17 – December 4</td>
<td>Mon, Tues &amp; Wed</td>
<td>5:30-9PM</td>
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<tr>
<td>Room: 326</td>
<td>No class Nov. 21</td>
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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 or Bristol Hospital 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 Application, Questionnaire, Hepatitis B, Abilities and Physical Verification forms.
- The Health Form with documentation is due by October 4.
- Mail or bring your forms to Continuing Education, located in Building 700 at Tunxis Community College, 271 Scott Swamp Road, Farmington, CT 06032.
- Complete the Essential Job Skills & Career Development course (information attached; write CRN in space provided on application form).

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. 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 by October 4. Only submit your health form once it is completed.

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

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.

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
COSTS ASSOCIATED WITH THE
PHLEBOTOMY TECHNICIAN PROGRAM
FALL 2018

$2,585 - program cost
Includes malpractice insurance (personal health insurance is recommended in case of
injury or exposure), administrative fee, books, uniforms, Essential Job Skills course, and
NHA certification exam.

- Payment in full: Visa, MasterCard, Discover, Amex; money order or check, paid at
the Continuing Education Office

- Payment Plan Option (3 payments, includes a $25 installment fee):
  $886.58 - due within five business days of acceptance
  $861.71 – due 9/17/18
  $861.71 – due 10/15/18
To use the payment plan option, contact the Continuing Education office
at least one day in advance, at 860 773-1448 or tx-continuing-ed@tunxis.edu.
You can then set up your payment plan in person at the Business Office
(Founders Hall).

$279 – Optional Externship – not included in tuition

Uniform includes:
Two pewter scrub tops/pants and a white lab coat; students will be given further
instructions. Uniform is worn at all times during the program.

Sneakers or nursing shoes (not open-toed) – purchased on your own

Books and uniforms will be distributed the first day of class.

This program is not eligible for federal financial aid.

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 860.899.3500.

Or check out www.chesla.org (Connecticut Higher Education Supplemental Loan Authority).
Required for Health Care Career Programs

Essential Job Skills & Career Development Course

This 14-hour course is designed to aid students in successfully transitioning into their chosen careers. Emphasis will be placed on the development of a resume, essential interview skills, and soft skills to give students the tools to secure and retain employment. Students will engage in mock interviews to develop these skills. Guest speakers will cover topics such as “what makes a successful employee” and “how to ensure a good interview.” Additional material to be covered will include team building, conflict resolution in the workplace and providing quality customer service. Please bring a USB drive and your present resume to class.

Room 6-174
Instructor: Karen Lyga, CMAA

Nov. 1, 8, 15, 29 (Th) or Nov. 2, 9, 16, 30 (F) or Nov. 3, 10, 17, Dec. 1 (S)
5:30-9pm or 9am-12:30pm or 9am-12:30pm
CRN: 3665 or CRN: 3666 or CRN: 3667

Please write in your preferred section where indicated on the top of the application form.
TUNXS COMMUNITY COLLEGE
PHLEBOTOMY TECHNICIAN PROGRAM 2018

PROGRAM CHOICE (choose only one): □ day □ evening

ESSENTIAL JOB SKILLS COURSE: CRN ________

Name ___________________________ Date of Birth ______________________
last first middle

Home Address __________________________ street __________ city __________ state __________ zip __________

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.

Briefly list employment history below.

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

________________________________________________________

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 __________________________

The information provided on this registration form is complete and accurate.
SPECIAL REQUIREMENTS
The following additional Essential Functions are also expected of all students with or without academic adjustments. Students must be able to fulfill the essential functions of the job without endangering patients or other healthcare workers. Students with disabilities may be eligible for academic adjustments.

Students must have the following abilities:

- Proficiency in the use of the English language and must possess effective oral and written skills in order to accurately transmit appropriate information to patients/clients, faculty, colleagues, and other healthcare workers
- Adequate senses – hearing and vision to perform the tasks required in the field of Phlebotomy.
- Fine and gross motor coordination
- Physical strength to transport, lift, move patients requiring all levels of assistance and perform prolonged periods of standing, bending, walking, reaching, pushing and pulling
- Intellectual, Emotional and Interpersonal skills to ensure patient safety, to exercise independent judgment and discretion in the performance of assigned responsibilities, and to interact with patients’ families, and other health care workers.
- Interpersonal skills such that you are capable of interacting with individuals, families and groups from a variety of social, economic and ethical backgrounds
- The ability to present a professional appearance, maintain personal health and be emotionally stable
- Arm-Hand Steadiness – The ability to keep your hand and steady while moving your arm or while holding your arm and hand in one position.
- Near Vision — The ability to see details at close range (within a few feet of the observer).
- Problem Sensitivity — The ability to tell when something is wrong or is likely to go wrong. It does not involve solving the problem, only recognizing there is a problem.
- Speech Clarity — The ability to speak clearly so others can understand you.
- Speech Recognition — The ability to identify and understand the speech of another person.
- Finger Dexterity — The ability to make precisely coordinated movements of the fingers of one or both hands to grasp, manipulate, or assemble very small objects.
- Selective Attention — The ability to concentrate on a task over a period of time without being distracted.
- Active Listening — Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
- Service Orientation — Actively looking for ways to help people.
- Critical Thinking — Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
- Time Management — Managing one’s own time and the time of others.

I have read and understand the information provided above.

__________________________________________  _________________
Sign                                      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

Mental health concerns? □ Yes □ No

Hearing problems? □ Yes □ No

Back problems? □ Yes □ No

Knee problems? □ Yes □ No

Recent surgeries? □ Yes □ No

Lifting restrictions?
(i.e. arthritis, injury, surgeries, etc.) □ Yes □ No

Latex allergy? □ Yes □ No

Please list any medications here: ____________________________________________

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:__________________________
TUNXIS COMMUNITY COLLEGE
CERTIFIED PHLEBOTOMY TECHNICIAN PROGRAM

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 their success in this course. You should be English proficient.)

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

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 describe.

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

What are your career goals?

How did you hear about this course?

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 _____

(OVER)  
Page 1
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
# STUDENT HEALTH FORM

## Applicant Information

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

<table>
<thead>
<tr>
<th>Sex</th>
<th>Marital Status</th>
<th>Date of Birth (month, day, year)</th>
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<tbody>
<tr>
<td>☐ Male</td>
<td>☐ Single</td>
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## Emergency Contact Information

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<tr>
<th>Name (last, first, middle)</th>
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<table>
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<tr>
<th>Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
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## Family History

- Cancer
- Tuberculosis
- Diabetes
- Allergy or Asthma
- Epilepsy or Convulsions
- Stroke
- Heart Disease
- Nervous or Mental Illness
- Migraine Headaches
- High Blood Pressure

Have any family member ever had the following:

- Cancer
- Tuberculosis
- Diabetes
- Allergy or Asthma
- Epilepsy or Convulsions
- Stroke
- Heart Disease
- Nervous or Mental Illness
- Migraine Headaches
- High Blood Pressure

## Personal History

**Question**

1. Have you ever had any operations and/or significant injuries?
2. Do you have any physical impairment? (e.g., paralysis, loss of hearing, vision)
3. Have you had any emotional problems requiring treatment?
4. Do you take any medications regularly?
5. Have you reacted unfavorably to any medication? (e.g., penicillin, aspirin)
6. Has your physical activity ever been limited?

**Yes** | **No**

## 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

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.

Date: **Parent’s or Guardian’s Signature**
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**.

**MEASLES** 1st dose: ____________________________ or Titer Immune? □ YES □ NO
date/given on or after 1st birthday & after Jan. 1, 1969

**MEASLES** 2nd dose: ____________________________
date/given after Jan. 1, 1980

**MUMPS**: ____________________________ or Titer Immune? □ YES □ NO
date/given on or after 1st birthday

**RUBELLA**: ____________________________ or Titer Immune? □ YES □ NO
date/given on or after 1st birthday

**POLIO**: ____________________________ or Titer Immune? □ YES □ NO
date(s) of immunization

**VARICELLA** (Chicken Pox): ____________________________ or Titer Immune? □ YES □ NO
date(s) of immunization

**Td** (TETANUS booster): ____________________________
date/must have been given within the last 10 years

**FLU** VACCINE (spring and fall applicants only) ____________________________
date given

**HEPATITIS B SERIES**: ____________________________ ____________________________ ____________________________
date/1st dose date/2nd dose date/3rd dose

**VARICELLA** (Chicken Pox): or Titer Immune? □ YES □ NO
date(s) of immunization

**TUBERCULIN TEST/PPD** (Mantoux or QFT-G): ____________________________
date given

**LEVELS**

**HEMATOCRIT OR HEMOGLOBIN** (Lab Reports Required)

**IMPORTANT!**
Attach lab reports or immunization records for everything listed.

**PHYSICAL EXAMINATION**

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<th>WEIGHT</th>
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<tr>
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<td>CORRECTION (R)</td>
<td>(L)</td>
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<td>(L)</td>
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<td>(Rhythm)</td>
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<td>(Murmurs)</td>
<td>(Blood Pressure)</td>
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<tr>
<td>LABORATORY</td>
<td>URINALYSIS</td>
<td>HEMATOCRIT OR HEMOGLOBIN</td>
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<tr>
<td></td>
<td>(Lab Reports Required)</td>
<td>(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).

DATE EXAMINING PHYSICIAN’S SIGNATURE ADDRESS TELEPHONE

PAGE 2 OF 2