Shasta College

Health Sciences & University Programs
HIT/HIM Part 1 Pre-Enrollment Clinical Requirements Checklist
Last Reviewed & Revised 10/01/2019

NAME: _____
(Please Print) **(Last)** **(First)** **(MI)** **Student ID #**

EMAIL ADDRESS: _____

This checklist is being provided to assist you in completing the documents **required** for the clinical experience component of the program (HIT 60 *Professional Practice Experience* or HIMS 455B *Advanced Professional Practice Experience*).

Submit **copies** of all original records together in a large manila envelope by the designated deadline. Incomplete packets will not be accepted. All materials will be verified and become the property of Shasta College and will not be returned to the student.

Hand deliver or mail to:
Shasta College Health Sciences Division
Attn: HIT/HIM Administrative Assistant
1400 Market Street, Suite 8204
Redding, CA 96001

Or email to:
hsupconnect@shastacollege.edu

Part 1 Pre-Enrollment Clinical Requirements Check-Off List: Steps A through E

☐ **A. Clinical Requirements Checklist -** Complete program "Clinical Requirements Checklist" form

1. **CPR Certification** for Healthcare Professional or Provider Level – Adult, Infant, Child, 2-rescuer resuscitation – valid 2 years. **NO ONLINE COURSES ACCEPTED.** Must provide copy of current card.
2. **Immunizations -** Submit copies of your original vaccine record or lab test results (titers) showing immunity:
   - Hepatitis B Series – 3 doses of vaccine or titer documenting immunity
   - Tetanus/Diphtheria/Pertussis (TDaP) - one-time dose of vaccine as adult; Td booster every 10 years following
   - Measles/Mumps/Rubella (MMR) - 2 dose vaccine series or titer documenting immunity
   - Varicella (Chickenpox) - 2 dose vaccine series or titer documenting immunity
3. **Tuberculosis (TB) Screening – 2-Step process is required**
   - The first TB screening must be within 12 months prior to class start date and turned in with the Part 1 Pre-Enrollment packet. The second TB screening is time-sensitive and is due with the Part 2 Pre-Enrollment packet.
   - Students with known positive Tuberculosis Screening (PPD) must complete TB Questionnaire - Confidential form, submit documentation of either a Quantiferon Gold TB blood test within the past year or a chest x-ray within the past two years, and receive clearance from their health care provider.
   - Students with a previous BCG vaccine may choose to obtain a Quantiferon Gold TB blood test (requires physician order). If a Quantiferon Gold TB test is required, please wait to complete until instructed to start the Part 2 Pre-Enrollment packet.

WARNING: Tuberculosis test must be done before, or a minimum of 30 days after, any live vaccination (MMR, Varicella) to avoid false positive.

☐ **B. Technical Standards Disclosure Sheet** – Must be able to perform all standards listed with or without accommodations. *A copy of the form must be provided to your health care provider at the time of your physical exam.*

☐ **C. Health Science Program CONFIDENTIAL Application for Clinical Practice** – Must see Dean or Program Director for any issues related to criminal history.

☐ **D. Student Data Form**

This information will be kept on file while you are enrolled in the program. It is your responsibility to notify the Health Sciences office of any changes in your contact information by filling out the contact information change form available on the Health Sciences website.

☐ **E. Signed Acknowledgment Forms**

a. Student Handbook Acknowledgment
b. Use of Electronic Devices Agreement
c. Student Honor Contract
d. Photography and Publication Release
e. Assumption of Risk and Release Form

Student Signature: _____ Date Submitted: _____

Make a personal copy of all records prior to submission to Health Sciences office.
If you have questions, contact the Health Sciences office at (530) 339-3600

Name _____

Date: _____

☐ **Health Information Technology** ☐ **Medical Assisting**
☐ **Health Information Management** ☐ **Medical Scribe**

SC STUDENT ID# _____

Directions: Complete all the sections below and turn into the Health Sciences Division Office along with a copy of your official immunization documentation. ***Students who cannot complete or provide documentation of immunization requirements by the designated deadline will not be allowed to enroll in a Health Sciences program.***

Student is to record immunization information on this checklist. (This form is a reporting document for Shasta College Health Sciences -- Not intended to be an official record from healthcare provider). Official immunization documentation must be attached.

CPR Certification - must show documentation of current certification in:	
Basic Life Support (BLS) for the Healthcare Professional including Adult, Child & Infant Resuscitation and two-person rescue. Certification must have American Heart Association (AHA) emblem. ⓘ **CPR certification will be included in the Medical Assisting Program.**	Expiration Date: _____

Tetanus, Diphtheria, Pertussis (TDaP) - must show documentation of either:	
A. **One-time dose of TDaP** (includes pertussis) required for all Healthcare Personnel younger than age 65. **OR**	Date _____
B. Subsequent Td booster every 10 years following one-time TDaP (must include proof of previous TDaP)	Date _____

Varicella* **-** must show documentation of either:	
A. **Two doses** of Varicella vaccine administered at least 4-8 weeks apart **OR**	Date #1 _____ Date #2 _____
B. Proof of quantitative IgG titer showing positive/immune to Varicella **If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2.	Date _____ Results _____
Options You must either: ***1)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer **OR ***2)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer	***Option 1:*** Original Series given: Date #1 _____ Date #2 _____ Date of Booster: _____ ***Option 2:*** Series given: Date #1 _____ Date #2 _____
* Note: A previous diagnosis of chickenpox is **NOT** accepted as proof of Varicella immunity. Must submit documentation of either A or B as outlined above.	

Measles, Mumps, Rubella (MMR) - must show documentation of either:	
A. **Two doses** of MMR vaccine administered at least 4-weeks apart **OR**	Date #1 _____ Date #2 _____
B. Proof of quantitative IgG titer showing positive/immune to Measles, Mumps, and Rubella **If titer shows as **negative OR equivocal immunity**, proceed to Option 1 or 2.	Measles: Date _____ Result _____ Mumps: Date _____ Result _____ Rubella: Date _____ Result _____
Options You must either: ***3)* provide proof of having previously received the original 2-dose vaccination series and having received one (1) booster after your negative titer **OR ***4)*** if you have no previous records, proof of obtaining the 2-dose series after your negative titer	***Option 1:*** Original Series given: Date #1 _____ Date #2 _____ Date of Booster: _____ ***Option 2:*** Series given: Date #1 _____ Date #2 _____

Hepatitis B - must show documentation of either:	
A. **Three doses** of vaccine. This series can be administered over a period of 4-6 months depending on your healthcare provider's preference; please start this series early. • **CDC standard recommendations are for series to be given at 0, 1, and 6 months.** • **CDC minimum requirements allow for series to be given at 0, 1, and 4 months.** **OR**	Date # 1 _____ Date # 2 _____ Date # 3 _____
B. Proof of Hepatitis B AB [antibody] Surface IgG titer (**NOT** AG [antigen]) showing positive/immune	Date _____ Results _____

Tuberculosis Screening - must show documentation of either:	
A. Two negative TB skin tests (PPD) results. 1st PPD must be completed within 12 months prior to program start date. 2nd PPD must be within 6 months prior to program start date. **OR**	Date # 1 _____ Result _____ **Date # 2 due with Part 2 Packet**
B. If PPD is positive or there is a history of positive PPD, there must be a record of a negative Quantiferon Gold TB test within the past year or chest X-ray within the past 2 years. A Confidential TB screening questionnaire must be completed by the student and healthcare provider. **OR**	Date _____ Results _____
C. If applicant has previously had the BCG vaccination, they may be eligible to take the Quantiferon Gold TB Test. (Please contact the Health Sciences office for more information.)	Date _____ Results _____

Influenza - must show documentation of:	
One dose of influenza vaccine annually during the recommended flu season (September through April). **DO NOT OBTAIN THE VACCINE OUTSIDE OF THE SPECIFIED FLU SEASON.** ***HIT/HIM students will submit this document with the Part 2 packet.**	Date _____

Student Statement: I hereby certify that all materials presented and all statements made are true and correct. I authorize investigation of all records submitted and am prepared to provide original documentation when requested. I understand that any misrepresentation of material facts may be cause for immediate disqualification and removal from the program.

Signature of Applicant: _____ Date: _____

For Health Sciences Division Use Only
Date Received:
Immunization official documentation verified by:
Notes:

Shasta College

Health Sciences & University Programs
Technical Standards Disclosure
HIT, HIM, Med Scribe, Pharm Tech - Health Sciences Programs

Last Reviewed & Revised 3/6/2019

In the interest of your own personal safety and the safety of your patients, there are significant requirements that must be met before your admission to the program is finalized. The attendance requirements and stamina demands requires the Health Sciences student to be in good physical and mental health. Please read this form carefully and initial each technical issue standard if you can comply with the standard. When complete, please sign, date and return original in your Pre-Enrollment Clinical Requirements Packet. **Note: This is a self-assessment – to be completed by you, not a health care provider.** *Applicants must present a copy of their completed Technical Standards to their healthcare provider for review at the time of the physical examination*. **Please see the Health Sciences Dean if you require an accommodation or cannot comply with the standard.**

Issue	Description	Standard/Physical Requirement	Initials
Mobility	Physical ability, flexibility, strength and stamina	Standard work day requires various abilities including standing, walking, sitting, bending, flexing, lifting, twisting, stooping, kneeling, reaching, stretching, pushing and pulling to gather and stock supplies, operate equipment (computers, various types of medical devices, etc.), and perform required functions of patient care. Often must lift, carry or move objects weighing up to 40 pounds.	
Motor Skills	Physical ability, coordination, dexterity	Gross and fine motor abilities sufficient to perform required functions of clinical placement assignments; hand-wrist movement, hand-eye coordination, and simple firm grasping required for fine motor-skills and manipulation; fine and gross finger dexterity required;	
Comprehension	Comprehend and process information; perform algebraic and complex calculations	Engage in written and oral directives related to clinical placement assignments, retaining information given by faculty/ healthcare providers to assimilate and apply to patient care; comprehend and process instructions accurately; perform mathematical functions/calculations regarding medication administration.	
Tactile	Use of touch	Normal tactile feeling required.	
Hearing	Use of auditory sense	Ability to hear and interpret many people and correctly interpret what is heard; i.e., healthcare provider, or supervisor orders whether verbal or over telephone, patient communications, fire and equipment alarms, etc.	
Visual	Use of sight	Interpret written words accurately, read characters and identify colors on the computer screen. Ability to operate a computer and/or laptop through proficient typing, clicking, and viewing a monitor for extended periods.	
Critical Thinking	Ability to problem solve	Integrate information through critical thinking based on information gathered during clinical sessions/ rotations, and during class sessions that are applied in the clinical process.	
Communication	Speak, read, write, & use English language effectively. Communicate effectively in interactions with others verbally, nonverbally & in written form	Effectively interacts with the environment and other persons. Fluent in English. Ability to communicate with wide variety of people and styles and to be easily understood. Reading, writing, recording, and documenting critical patient information required.	
Behavioral	Emotional & mental stability	Functions effectively under stress; flexible, concern for others; able to work in environment with multiple interruptions and noises, distractions, and unexpected clinical assignment changes.	

_____ _____ _____

Print Name **Student Signature** **Date**

Indicate program of application:	
☐ Associate Degree Nursing (RN) ☐ Dental Hygiene (DH) ☐ Health Information Technology (HIT) ☐ Health Information Management (HIM) ☐ Medical Assisting (MA) ☐ Medical Scribe	☐ Nursing Assistant/Home Health Assistant (NA/HHA) ☐ Pharmacy Technician ☐ Physical Therapy Assistant (PTA) ☐ Vocational Nursing (LVN)

Applicant information:				
Last Name	First Name	MI	Maiden	
Address	City		State	Zip
Email				
Phone (day)	Phone (eve)	Phone (cell)		

Criminal Public Record Check:	
☐ Yes ☐ No	Have you ever been convicted[1] of any crime[2] under your current name or any other name? ***If the above answer is yes, please detail information for each conviction on the back of this form.***
☐ Yes ☐ No	Do you have a criminal case now pending?
☐ Yes ☐ No	Clinical assignments are in health facilities that allow access to drugs and medications. Have you ever been arrested for an offense involving controlled substances? *(Cal Labor Code 432.7f, Cal Health and Safety Code 11590)*
☐ Yes ☐ No	Clinical assignments are in health facilities that allow you regular access to patients. Have you ever been arrested for a sex offense for which registration as a sex offender would be required upon conviction? *(Cal Labor Code 432.7f, Penal Code 290)*
☐ Yes ☐ No	Do you understand that a background check; reference verification; and drug screening, is a part of the enrollment decision making process, and if you are invited to participate in the program that you consent to complete a background investigation?

[1] "Convicted" means plea, verdict of finding of no contest or guilt, regardless of whether sentence was imposed by the court.

[2] "Any crime" means misdemeanors or felonies including motor vehicle/driving violations excluding minor traffic infractions, conviction for marijuana more than two years ago, and convictions for which the records has been sealed, expunged, eradicated, or judicially dismissed.

Applicant Statement

I hereby certify that all statements made on this form are true and correct, and I authorize investigation of all statements herein recorded. I release from liability persons and organizations reporting information required by this application. I understand that any misrepresentation or falsification of material facts in this application may be cause for immediate disqualification and removal from program.

Signature of Applicant: _____ **Date:** _____

**Existence of convictions will not necessarily disqualify an applicant from enrollment. However, failure to fully disclose may be considered falsification and will result in offer of enrollment being rescinded; and is grounds for immediate termination upon discovery at any time during enrollment.*

Information Regarding Criminal History:					
Date	**Conviction**	**Conviction Type**	**Court Name**	**City**	**County**

Exclusion from Clinical Placement

In collaboration with the clinical agencies used by Shasta College, a student will be excluded from participation in clinical rotations and therefore unable to complete the Shasta College Health Sciences programs for the following background check/drug screen findings:

- Capitol felony conviction at any time in student's past
- Felony conviction within past 7 years[3]
- Misdemeanor convictions with past 3 years[3]
- Medicare fraud
- Any crime that results in requirement to register as a sex offender
- Positive drug screen

[3]Note: Felony or misdemeanor convictions involving crimes against persons or property, any drug charges, and driving under the influence must fall outside the above time lines for students to be eligible for enrollment.

There are some specific restrictions imposed by the State for the Dental Hygiene students and Nurse Assistant/Home Health Aide** students which require additional clearance.

***For individuals applying to the Nurse Assistant/Home Health Aide program that have any convictions or have questions about their ability to obtain the DOJ background clearance, they may request an "inquiry" with the California Department of Public Health.*

Signature of Applicant: _____ **Date:** _____

**Existence of convictions will not necessarily disqualify an applicant from enrollment. However, failure to fully disclose may be considered falsification and will result in offer of enrollment being rescinded; and is grounds for immediate termination upon discovery at any time during enrollment.*

Date _____

Health Information Technology or Health Information Management Program Student Data Form

This information to be kept on file with the Health Sciences Division while you are enrolled in either the Health Information Technology (HIT) or Health Information Management (HIM) program.

Student Name:

_____

Student ID#: _____

Age: _____ **Birthdate:** _____

☐ Male ☐ Female

Address:

_____

_____

County of Residence: _____

Email: _____

Phone: _____**Alternate #:** _____

Are you a re-admit student from the Shasta College HIT/HIM program? ☐**Yes** ☐**No**

Have you started, but did not complete, another HIT/HIM Program? ☐**Yes** ☐**No**

If yes, what school did you attend and what was the reason for not completing that program? _____

_____

Do you have previous work experience in a healthcare facility? ☐**Yes** ☐**No**

If yes, in what position? _____

_____

Are you a veteran? ☐ **Yes** ☐ **No**

Are you sponsored by: ☐ **Smart Center** ☐ **CalWORKS** ☐ **other**

Are you receiving Financial Aid for school? ☐ **Yes** ☐ **No**
(i.e. California College Promise Grant, Pell Grant, Scholarship, Loan)

Ethnic Background:

☐	**Asian**	☐	**Hispanic**
☐	**Black**	☐	**Native American**
☐	**Caucasian**	☐	**Pacific Islander**
☐	**Filipino**	☐	**Other**

Student Handbook Acknowledgement

I have received, reviewed and sought clarification of the Student Handbook and its contents. I am aware that this Manual:

- is referenced in the Course Information handouts for the program
- makes reference to the current Shasta College Catalog
- includes the policies referenced in the Student Handbook

I have received the Course Information. I am aware that I can find the Shasta College Catalog online at www.shastacollege.edu.

I have read the entire Student Handbook and understand my responsibilities as a student in the Health Sciences program to be accountable for the standards set forth in the Student Handbook.

I realize that periodic quizzes will be given by the faculty to validate my knowledge and understanding of the handbook content and program policies.

I understand that departmental policies and handbook information are subject to revision throughout my program and I am responsible for remaining current on these changes.

This acknowledgement will be placed in my student file.

_____ _____

Name of Student (Printed) Date

_____

Name of Student (Signature)

Use of Electronic Devices Agreement

I have reviewed and sought clarification of the Standards for Use of Electronic Devices. I am aware that I can find the Standards for Use of Electronic Devices online.

I understand these standards are designed to protect individual and patient rights and that I have the responsibility to be aware of confidentiality issues and maintain appropriate conduct in the use of electronic devices both during classroom/clinical skills sessions and during clinical experiences in the healthcare facilities.

I understand that violation of the standards for use of electronic devices in the classroom and clinical skills lab setting will result in the loss of the privilege of using such devices to support my learning strategies and may result in being placed on contract by instructor.

I understand that violation of the standards for use of electronic devices during clinical experiences in the healthcare facilities and within patient care areas will result in the loss of the privilege of using such devices to support my clinical care activities and learning and will result in being placed on contract by my instructor.

I understand that violation of the standards may result in HIPAA violation claims against me and that I could be liable for consequent legal action.

In addition, I understand that according to the program's Dismissal policy, a HIPAA violation is cited as an example of an incident or clinical situation that puts the patient, student, clinical affiliate, faculty or college at risk and therefore, deems the student subject to dismissal from the Health Science program.

This agreement will be placed in my student file.

_____ _____
Name of Student (Printed) Date

_____
Name of Student (Signature)

Health Science Program Honor Contract

I understand that Health Sciences Division Program students are expected to maintain an environment of academic integrity. I further understand that actions involving scholastic dishonesty violate the professional code of ethics. I have been informed and understand that any student found guilty of scholastic dishonesty is subject to dismissal from the Health Science Program and may be ineligible for re-admission.

I have read the Scholastic Honesty Standard in the Health Sciences Program Student Handbook. I understand the Scholastic Honest Standard and I agree to fully abide by this stated policy.

_____ _____
Name of Student (Printed) Date

_____
Name of Student (Signature)

Student Photography and Release Policy

Photographs of the student may be taken during course activities (non-client contact) and utilized by the program for professional educational activities (i.e. bulletin boards, audiovisual presentations, pamphlets, catalogues, websites, etc.).

It is the responsibility of the student to notify the photographer at the time if they do not wish to have their photograph taken or utilized. Signing the Shasta College Publication Release Form signifies that the student has read and understood this policy, and gives the college permission to use the print or digital reproduction at its sole discretion.

Publication Release Form

I have voluntarily agreed, without compensation of any kind, to appear or allow my art work or image to appear in any print, film, digital likeness or videotape produced by the Shasta-Tehama-Trinity Joint Community College District.

The Shasta-Tehama-Trinity Joint Community College District shall have the right and may grant to others the right to disseminate, print, alter and publish my name, likeness and biographical material, in connection with any publicity and promotion of the print, film, digital likeness, videotape or art work, except for the direct endorsement of any product.

I hereby release and discharge the Shasta-Tehama-Trinity Joint Community College District and its respective agents, employees, successors, assigns, and licensees from any and all claims, liabilities and obligations of any kind of nature that may arise from my appearance or participation or art work incorporated in the print, film, digital likeness or videotape of any exhibition thereof.

I agree that the Shasta-Tehama-Trinity Joint Community College District has no obligation to exhibit or televise my performance or art work or otherwise use my likeness or art work in its print, film, digital or videotape.

Signature: _____

Print Name: _____

Date: _____

I, _____, wish to enroll in and participate in the following class:
Print Name

Indicate program of application:	
☐ Associate Degree Nursing (RN)	☐ Medical Scribe
☐ Dental Hygiene (DH)	☐ Nursing Assistant/Home Health Assistant (NA/HHA)
☐ Health Information Technology (HIT)	☐ Pharmacy Technician
☐ Health Information Management (HIM)	☐ Physical Therapist Assistant
☐ Medical Assisting (MA)	☐ Vocational Nursing (LVN)

Please initial each of the following statements.

____ **Release of Liability and Waiver**: In return for being permitted to enroll and participate in the above Program, including any associated use of the premises, facilities, staff, equipment, transportation, and services of the Shasta-Tehama-Trinity Joint Community College District (District), I, for myself, heirs, personal representatives, and assigns, **do hereby release, waive, discharge, and promise not to sue** the District, the Board of Trustees, directors, officers, employees, and agents (collectively the "District"), from liability **from any and all claims, including the negligence of the District**, resulting in personal injury (including death), accidents or illnesses, and property loss in connection with my participation in the Program and any use of District premises and facilities.

____ **Assumption of Risks: I understand that enrollment and participating in the Program** involves the risks associated with blood borne pathogens and the other activities described in the course outline of record. I further understand that certain inherent risks in the Program cannot be eliminated regardless of the care taken to avoid injuries.

I have been advised and am aware of the risks associated with enrolling and participating in the Program, which include but are not limited to physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss, and/or death. I understand that these injuries or outcomes may arise from my own or other's actions, inaction, or negligence or the condition of the Program location(s). Nonetheless, I assume all related risks, both known or unknown to me, of my participation in the Program and further agree to accept all Program rules and requirements for the program participation, travel policies, program schedules, and to follow the instructions given by supervisory personnel involved in the program and related classes.

I am voluntarily participating in the Program and I acknowledge and fully assume the risks associated with my enrollment and participation.

____ **Indemnification and Hold Harmless:** I also agree to **indemnify and hold the District harmless** from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, arising out of my involvement in the Program, and to reimburse it for any such expenses incurred.

____ **Medical Certification and Consent:** I certify that I am physically capable and have received medical clearance for participating in the Program and that I have no medical condition which would interfere with my ability to safely participate. In the event of any medical emergency, as determined by District supervisory personnel, I authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical procedure or treatment, and hospital care deemed necessary for my safety and protection.

Signature required on Page 2

____ **Governing Law and Severability**: I understand that this document is written to be as broad and inclusive as legally permitted by the State of California and agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms. I agree this Agreement shall be governed by the laws of the State of California, and any disputes arising out of or in connection with this Agreement shall be under the exclusive jurisdiction of the Courts of the State of California.

____ **Understanding and Acknowledgement:** I have read all previous paragraphs, including the release of liability and waiver, assumption of risk, and indemnity agreement, know, fully understand its terms, acknowledge these and other risks that are inherent to the Program, and **understand that I am giving up substantial rights, including my right to sue. I acknowledge my participation is voluntary, that I knowingly assume all such risks**, and that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the extent allowed by law. No other representations concerning the legal effect of this document have been made to me.

I am 18 years or older. I have read this document and fully and completely understand the potential risks that may be associated with the Program. I am signing this document freely.

Participant's Name: _____

Signature: _____ Date: _____

If Participant is under 18 years of age: I am the parent or legal guardian of the Participant. I have read this two-page document, and I am signing it freely. I understand the legal consequences of signing this document, including (a) release of District from all liability on my and the Participant's behalf, (b) waiver of my and the Participants' right to sue, (c) and assumption of all risks of the Participant's participation in the Activity including travel to and from. I allow Participant to participate in this Activity and I understand that I am responsible for the obligations and acts of Participant as described in this document. I agree to be bound by the terms of this document.

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

All students applying for Health Sciences Programs will need to have a current CPR certification that meets five (5) specific criteria. The selected course must be at the **(1)** ***Healthcare Provider*** level. The course will include **(2)** Basic Life Support (BLS) for adult, child and infant CPR and **(3)** 2-rescuer resuscitation with hands-on practicum and testing. The certification card issued must include the **(4)** American Heart Association (AHA) logo and **(5) No online courses are accepted.**

WHERE CAN YOU OBTAIN A CPR CERTIFICATION FOR A HEALTH PROFESSIONAL?

SHASTA COLLEGE – FAID 133 CPR Professional Rescuer
(See current semester class schedule for available classes.)

A+ SAFETY – (530) 222-1210
2765 Bechelli Lane, Redding CA 96002
Website: www.aplussafetyllc.com

CENTER FOR EXCELLENCE IN EDUCATION - (530) 873-6683
Peggy Tyranski - pstyranski@gmail.com
Website: CEEMED.com

MED ED – (530) 276-9164
1615 Continental Street, Redding CA
donnaconrad@shasta.com

ALBERTSON TRAINING CENTER – (530) 527-4997
80 Gurnsey Avenue, Red Bluff 96080

CPR Pro, First Aid, EMR – (530) 921-1455
Serving Shasta, Tehama, and Siskiyou Counties
austin.kiser1@gmail.com

Additional resources within our community may meet the criteria listed above as well.