Medical Assisting Program
Part 1 Enrollment Packet Check List

This checklist is provided to assist you in completing the Medical Assisting Part 1 Enrollment Packet. **Submit copies of all forms to the Health Sciences Division Office. Records will not be accepted separately.**

Last Name	**First Name**	**MI**
Address		
City	**State**	**Zip**
Shasta College Student ID #	**E-mail address**	
Phone (day)	**Phone (eve)**	**Phone (cell)**
What languages do you speak?		
Have you previously attended the Shasta College MA Program? If yes, when?		

☐ **A. CONFIDENTIAL Application for Clinical Practice** - Must see Dean or Program Director for any issues related to criminal history.

☐ **B. Acknowledgment Forms**

Please review the following policies/forms:

- Use of Electronic Devices Agreement
- Student Honor Contract
- Photography and Publication Release
- Assumption of Risk and Release Form

PLEASE REVIEW & SIGN

I understand that while enrolled in the Medical Assisting program:

- I am required to submit a complete Part 2 Pre-Enrollment packet, which includes proof of immunizations, prior to enrollment in the second semester (ALH 103 & 104). I will be provided with a deadline by which I must submit the required documents.
- That one of the immunization series is for Hepatitis B and that the series takes **4 – 6 months to complete**
- It is highly recommended that I immediately begin Item C of the Part 2 packet and gather my records to ensure I have sufficient time should I need to obtain a vaccination series.
- That failure to submit a complete Part 2 packet by the deadline will prevent me from proceeding into the next semester.

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

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

Student 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.

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 Student: _____ **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** (misdemeanor/felony)	**Court Name & Location** (city & state)
Example: 1/1/2010	Driving under the Influence (DUI)	Felony	Shasta County Superior Court Redding, CA

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 within 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.

For more information regarding clearance needed to apply for certification or licensure, please contact the accrediting board for your program.

Signature of Student: _____ **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.*

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: _____