FORMS TO BE SIGNED AND RETURNED TO THE PROGRAM DIRECTOR

Western Nebraska Community College

Health Science Division
Medical Laboratory Technician Program (MLT and Phlebotomy)

John N. Harms Center, Scottsbluff

Student Full Name: Program: □ PBT □MLT

Faculty Advisor: Student ID:

PBT/ MLT ADMISSION CHECKLIST	Date Completed
High School Transcript or Diploma or GED Certificate or College Transcript {If Applicable)	
E **COMPASS/ACCUPLACER/ACT/SAT** Scores	
PBT/MLT Program Application form	
Copy of Driver's License	
Signed Copv of Student Intern Basic Information	
Signed Copy of Acknowledgment of Health Insurance	
Signed Copv of Authorization to Release Information	
Signed Copy of Disclosure of Expo sur e to Potential Health Risks and Waiver of Liability	
Signed Copv of Human Subject Documents	
Signed Copy of HIPPA Letter of Instruction	
Signed Copv of Confidentiality Statement	
Signed Copy of Substance Abuse Policy Release	
Signed Copv of Authorization to Obtain Background	
Signed a copy of Declaration of Student	
Signed Copy of Student Handbook Agreement	
Signed Copy of Health History Questionnaire	
Background Check Report	
Proof of immunity or vaccination Report	

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

APPLICATION FOR ADMISSION FORM

John N. Harms Center, Scottsbluff

WNCC Phlebotomy Technician and Medical Laboratory Technician Programs have a Selective Admission Process. This process is non-discriminatory based on race, color, national origin, gender, age, qualified disability, marital status, veteran's status, or sexual orientation in admission to the program

Please indicate Medical Laboratory Science Program Applying for:

☐ Phlebotomy Technician (PBT) Certificate Program

☐ Medical Laboratory Technician (MLT) Associates in Applied Science Degree

A. Personal Information

Last Name	First Name	Middle Name	Date of Birth

Mailing Address	City	State	Zip Code

Home Phone	Work or Cell Phone	Email Address

B. Person to Notify during school or clinical practicum hours in case of emergency

Name:
Relationship:
Address :
Contact's Telephone :

C. Educational History

Provide information concerning high school, college, university, vocational or other trade schools attended (All official transcripts must be submitted along with this application form).

High School

Vocational or Trade School

Name of School:	
City & Stat e:	Completion Date:
Major:	Diploma/Degree:

College or University

Name of School:	
City & State:	Completion Date:
Major:	Diploma/Degree:

If presently, enrolled at any other college/university, what courses are you enrolled in?

List other non-traditional educational experiences (travel, military services, on the job training, etc.) that you think may be relevant in helping the program director evaluate your application.

List any previous health professional training or proof of current certifications from an accredited institution (eg. CPR, BNA, EMT, LPN-C, LR, MR)

D. Employment History

list your professional and/or business experience below:

Name of Employer:	Phone:
Address of Employer:	
Dates of Employment:	Position:
Job Responsibilities:	

E. Career Goals

Explain why you are interested in this program.

What personal attributes or skills do you bring to this program?

What obstacles do you have in completing this program?

Describe how you plan to overcome these obstacles. Include assistance that you would like to request of WNCC.

F. Attach Documentation:

☐ High School Diploma or GED or College Transcripts

☐ eCompass Assessment/ACCUPLACER scores or copy of ACT/SAT scores

☐ Copy of Driver's License (Proof of Age)

☐ Copy of Health Care Insurance

☐ Signed Copy of Student Handbook Agreement

☐ Signed Copy of Confidentiality Statement

☐ Signed Copy of Consent for Drug Screening

☐ Signed Copy of Authorization to Obtain Background Reports

_____ am indicating that the information I have included on my application is true. I understand misrepresentation or omission of information on this application, including my signature, may result in the loss of eligibility for admission into the program for which I am applying.

Applicant's Signature:	Date

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

STUDENT INTERN BASIC INFORMATION

John N. Harms Center, Scottsbluff

Term: ☐ Fall ☐ spring ☐ Summer

Program: ☐ **PBT** ☐M LT

Name:

Sex: ☐ Male ☐ Female

Permanent Address:

Home Phone:

Cell Phone:

Email:

Emergency Contact:

Emergency Phone:

Relationship:

Course Instructor: Dr. Mwafaq Haji, DVM, MSc,.MSc,.ML,S(ASCPi)cm SCicm

Course Instructor Contact Number: 308-635-6124

Course Instructor Email: hajim5@wncc.edu

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

ACKNOWLEDGEMENT OF HEALTH INSURANCE

John N. Harms Center, Scottsbluff

I have read the student policy regarding health insurance and acknowledge that health insurance coverage is solely my responsibility as a student of the Phlebotomy Technician and Medical Laboratory Technician program at Western Nebraska Community College. I have provided proof of health insurance coverage to the program faculty. I further understand that should this verification be fraudulent or should I allow my coverage to lapse, I am solely responsible for all expenses incurred for all accidents or illnesses, which may occur as a result of exposure to the clinical or laboratory environment.

Program: □ PBT □ MLT

Print Student Full Name: Date:

Student Signature: Student ID Number:

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

AUTHORIZATION TO RELEASE INFORMATION

John N. Harms Center, Scottsbluff

STUDENT INFORMATION:		
Name:		Student ID:
DOB:	Phone No:	Cell No:
Address :		
City :	St ate :	Zip :

As a student enrolled at the Western Nebraska Community College, I give permission for WNCC to release the following information from my student records:

--- Immunization/Vaccination records

____ Health Insurance Card

____ CPR Card

____ Drug Screen Results

____ Background Reports

____ Other (please specify) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

This information can be released to:

Name_ _

Address_ _

City/St ate and Zip _

This information is requested for the purpose(s) of:

--- ____

____ Recruitment

Employment

Clinical affiliation requirements

____ Other (please specify) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

I hereby grant permission to WNCC, Medical Laboratory Science (PBT, MLT) Program to release the above information if the College deems doing so necessary. I also give permission to release information regarding my professional qualities, academic achievement, and clinical performance to the MLS Program Director when responding to requests for employment consideration. This release does not include any information submitted by me or at my direction relating to medical records or reasonable accommodations under the Americans with Disabilities Act. This authorization is valid for two (2) years and may be revoked at any time. Revocation of this authorization must be made in writing to the MLS Program Director. WNCC is not liable for release made prior to revocation.

Program: D **PBT** D **MLT**

Print Student Full Name: Date:

Student Signature: Student ID Number:

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

DISCLOSURE OF EXPOSURE TO POTENTIAL HEALTH RISKS AND WAIVER OF LIABILITY

John N. Harms Center, Scottsbluff

During the course of clinical or laboratory components of the Phlebotomy Technician, and or Medical Laboratory Technician programs at the Western Nebraska Community College, students may come into contact with diseases, medicines, treatments, and equipment which are potentially hazardous to the student's health, or to the health of an unborn fetus, in the case of pregnant students.

Examples of potential hazards to which exposure may occur include, but are not limited to bacterial diseases (staphylococcal, streptococcal); mycotic diseases (Coccidioidomycosis); tuberculosis; viral diseases (AIDS, Hepatitis); radioactive materials and radiation; and rabies (Veterinary Technology Program). It is possible that exposure to other hazards may occur, as well. Although reasonable efforts are made to avoid and minimize these risks, the exact probability of exposure to these potential hazards is not known.

The student may be required to enter areas where access is restricted due to the storage, transfer or use of radiation sources. Prior to extended work in these areas, students will be given appropriate instruction in precautions, protective devices, and educated about problems which may be encountered in these areas. Students shall comply with requirements of the WNCC licenses and registrations which may apply in these restricted areas.

Students will be given instruction in infection control procedures, and other techniques for minimizing the risks of exposure to potential hazards. Once this instruction is provided, students will be expected to care for infected clients. Exceptions to this requirement are outlined in the PBT program handbook. Refusal to carry out assignments with infected clients would be contrary to both the educational and professional objectives of the clinical programs.

Because of potential health risks to both parent and unborn child, WNCC strongly recommends female students give serious consideration to the avoidance of pregnancy during the clinical education portion of the program. It is strongly recommended that pregnancy be disclosed as soon as possible by notifying the program director or director of allied health. Instructors will attempt to accommodate the student with alternate clinical assignments whenever possible. Areas of special concern are infectious/communicable diseases, noxious fumes such as nitrous oxide, radiation and antineoplastic agents.

There is also a higher risk of danger to students who have compromised immune systems. Immunosuppression occurs when the bodys ability to fight infections and other diseases is impaired due to inhibition of the body's normal immune responses. Typical conditions, which result in immunosuppression, include HIV infection/AIDS, chemotherapy, steroid therapy, and anti-rejection drug therapy for organ transplantation. Students who suffer immunosuppression on may consider withdrawing from the clinical program for so long as the immunosuppressive condition continues.

Each student enrolling in the clinical program must read this disclosure and waiver before instruction begins. Further, as a part of the consideration for the clinical programs and instruction provided, each student must give up any and all claims for injuries which may arise from the potential hazards and risks described above. Each student shall complete and turn in to the program director the *Waiver of Liability*.

I have received and read the above statement *Disclosure of Exposure to Potential Health Risks.* By participating in the clinical or laboratory program, I waive any and all claims and causes of action, present and future, against Western Nebraska Community College and their respective officers, agents and employees arising out of my participation in clinical or laboratory program and resulting injury, physical or mental illnesses, disability, or death.

I acknowledge that this waiver is made freely, voluntarily and under no compulsion.

Program: D PBT D MLT

Print Student Full Name: Date:

Student Signature: **Student ID Number:**

**Students under age of 18*

Print Parent or Guardian Full Name: **Date:**

Parent or Guardian Signature:

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

HUMAN SUBJECTS DOCUMENT

John N. Harms Center, Scottsbluff

General Information:

During this course you will be participating in laboratory activities in which learning by students requires the use of human subjects as part of the training. As a part of these learning activities, you will be asked to perform specific skills as well as be the subject of specific skills practiced by students. These learning activities will be conducted under the supervision of the course instructor.

Benefits:

The activities listed have been selected because they are skills essential to the learning process and the faculty believe that realistic practice is essential for optimum learning.

Blood borne Pathogen Exposure:

It is important that you be aware that blood and other body fluids have been implicated in the transmission of certain pathogens, particularly Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV), the virus responsible for Acquired Immune Deficiency Syndrome (AIDS). In order to minimize risk of exposure to blood borne pathogens, the student must agree to follow Standard Precautions guidelines as well as comply with regulations outlined in the OSHA Blood borne Pathogen Standard.

Risks/Discomforts:

Participation may create some anxiety or embarrassment for you. Some procedures may create minor physical or psychological discomfort. Specific risks are listed below.

Your Rights:

You have the right to withhold consent and to withdraw consent after it has been given. You may ask questions and expect explanation of any point that is unclear.

Learning Activity	Specific Benefit	Risks/Discomfort
Venipuncture using both evacuated tube system (ETS) and syringe system	Student gains experience needed prior to performing procedures on actual patients	Possibility of hematoma or bruising; slight, temporary pain with procedure; slight risk of temporary nerve inflammation
Skin puncture of the finger tip	Same as above	Slight, temporary pain upon puncture; minimal possibility of infection (provided area is kept clean)
Optional Learning Activity	**Specific Benefit**	**Risks/Discomfort**
Skin puncture of the forearm for Bleeding Time Test (BTT)	Same as other activities listed above	Same skin puncture activity listed above; plus possibility of a small scar at incision site

I have read the above Human Subjects Document. I acknowledge my understanding of the risks and benefits described. My questions have been answered. I agree to participate as a subject in the learning activities listed above.

_____ _____

Signature of student Date

(or parent or guardian if student is under 18 years of age)

Printed Name and Address _____

_____

Western Nebraska Community College

Health Sciences Division

Medical Laboratory Science Programs {PBT, MLT)

HIPAA LETTER OF INSTRUCTION

John N. Harms Center, Scottsbluff

As a student of the Phlebotomy Technician, and/or Medical Laboratory Technician Program of Western Nebraska Community College with access to health information, a student is expected to maintain the privacy and confidentiality of patient and/or student health information, as well as personal information such as age, address, telephone, marital status, etc. The federal Health Insurance Portability and Accountability Act (HIPAA) mandate requirements designed to enhance patient privacy.

The violation of these rules could result in significant civil and criminal penalties for the student and WNCC, particularly if an improper disclosure of information is done knowingly and for personal gain. The student will receive training regarding these rules. In general, however, disclosure of health information to anyone other than the patient typically requires the patient's express written authorization except in the following situations: (1) to employees who need the information for their job, or to a supervisor, (2) to medical providers for treatment purposes, or (3) to an insurance company to obtain payment for services.

As part of your responsibilities, you are expected to comply with HIPAA and all procedures developed for its implementation. Violation of these rules may result in discipline up to, and including, termination for a first offense. If you have questions, please discuss it with your instructor or the designated privacy officer.

Please acknowledge receipt of this letter by signing below.

Program: □ PBT □MLT

Print Student Full Name: Date:

Student Signature: **Student ID Number:**

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

CONFIDENTIALITY STATEMENT

John N. Harms Center, Scottsbluff

The undersigned understands that all medical information acquired as a result of their participating in work and/or health care activities at Facility is confidential and that the undersigned is prohibited from disclosing that information to any person or persons not involved in the care or treatment of the patients, in the instruction of Students, or in the performance of administrative responsibilities at Facility. The undersigned agrees to protect the confidentiality of patient information as required by law at all times both during and following his or her relationship with Facility. Conversations between physicians, nurses, and other health care professionals in connection with or in the presence of a patient receiving care or between the undersigned and a patient are also protected and may not be discussed. The undersigned recognizes that other sources of medical information include medical records, emergency room department, and ambulance records, child abuse reporting forms, elderly abuse reporting forms, laboratory requests and results, and x-ray requests and results. The undersigned understands that a breach of this confidentiality by him or her may result in an action for damages against him or her as well as against Facility. Facility may terminate the undersigned's relationship with Facility based upon a single breach of confidentiality by him or her:

Program:□ PBT □MLT

Print Student Full Name: Date:

Student Signature: **Student ID Number:**

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

SUBSTANCE ABUSE POLICY RELEASE

John N. Harms Center, Scottsbluff

!, _, recognize that the use and abuse of alcohol, drugs or substances can create an unsafe clinical working environment for myself and others. I have been informed that as a condition of my participation in Western Nebraska Community College Phlebotomy Technician, Medical Laboratory Assistant Program and/or Medical Laboratory Technician. I agree to provide a blood, urine and / or breath sample to the drug testing laboratory designated by Western Nebraska Community College, MLS Program. I agree that Western Pathology Consultants Inc., a drug testing facility, is authorized by me to provide the results of this test to WNCC. I agree to indemnify and hold WPCI harmless from and against any and all liabilities or judgments arising out of any claimrelated to (1) compliance with federal and state law, or (2) WNCC's interpretation, use (including MLS program selection/termination decisions) and confidentiality of the test results, except where WPCI is found to have acted negligently with respect to such matters.

I understand that if I fail to cooperate with a testing procedure, or in the case of a positive test result, I may not be allowed to participate in the PBT, and/or MLT program at WNCC or I may be terminated from a program.

I understand that if a test is positive for a controlled substance, I must be able to produce a prescription for that drug. The drug must be prescribed for me and the prescription must be from the medical doctor licensed to practice in the United States.

Program: □ **PBT** □ **MLT**

Print Student Full Name: Date:

Student Signature: **Student** ID **Number:**

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

AUTHORIZATION TO OBTAIN BACKGROUND REPORTS

John N. Harms Center, Scottsbluff

WNCC DISCLOSURE REGARDING BACKGROUND REPORTS

With your authorization, ***Western Nebraska Community College*** (the "Organization") will obtain a background report about you for purposes of your participation in an educational program with it, which may include participation in a clinical or other similar program(s). The authorization you give will allow the Organization to obtain this report, as well as additional reports, before and during your attendance there. These reports may include information about your character, general reputation, personal characteristics and/or mode of living, whichever may be applicable. Contained in these reports may be criminal record information about you, information about your prior employment, education, licenses and certifications or other background information about you.

WNCC AUTHORIZATION TO OBTAIN BACKGROUND REPORTS

I certify that I have received, read and understand the separate documents entitled Disclosure Regarding Background Reports, Disclosure Regarding Investigative Background Reports (if applicable) and A Summary of Your Rights Under the Fair Credit Reporting Act. I authorize Western Nebraska Community College, (the "Organization"), to obtain background reports regarding me. To this end, I authorize any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, insurance company and any other person or entity to furnish any background information about me. I agree that a facsimile, electronic or photographic copy of this authorization shall be as valid as its original.

Program: □ PBT □ MLT

Print Student Full Name: Date:

Student Signature: **Student ID Number:**

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

DECLARATION OF STUDENT RESPONSIBILITIES

John N. Harms Center, Scottsbluff

As required by my program of study, I_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ hereby state, represent, and agree to the following:

1. **Physical Examination:** I agree to obtain a physical examination within one year prior to entering into the Training Experience at a facility and to provide proof of the following:
    a. Drug screen: Negative results to a 10-panel drug screen.
    b. Tuberculosis: Proof of non-infectivity with pulmonary tuberculosis by completing either:
        (1) Two-step TB skin test (TST) for students with no history of positive TST or who have not been tested in the last 365 days.
        (2) Quanntiferon Gold TB Test.
        (3) Negative chest x-ray for students with proof of past positive TST.
    c. Measles (rubeola): documented receipt of two doses, documented history of the disease, or serological evidence of immunity, or born in the year 1956 or earlier, or statement of religious or medical refusal.
    d. Mumps: documented receipt of two doses, documented history of the disease, or serological evidence of immunity, or born in the year 1956 or earlier, or statement of religious or medical refusal.
    e. Rubella: documented receipt of two doses, documented history of the disease, or serological evidence of immunity, or born in the year 1956 or earlier, or statement of religious or medical refusal.
    f. Chicken pox (varicella): documented receipt of two doses, documented history of the disease, or serological evidence of immunity, or born in the year 1956 or earlier, or statement of religious or medical refusal.
    g. Hepatitis B: documented receipt of three doses, or serological evidence of immunity, or statement of religious or medical refusal.
    h. Tetanus and diphtheria: documented inoculation within ten (10) years
    i. Communicable diseases: Certification from a licensed physician that I am free of any casually transmitted communicable disease in a contagious state.
2. **Background check:** J agree to obtain, at my own cost a criminal background check to include, minimally an outstanding warrants search, statewide criminal search, fingerprinting (required by law in Nebraska, Colorado, South Dakota or Wyoming), a Department of Motor Vehicle Records search, and civil and criminal public filings for the State of Nebraska (hereinafter collectively referred to as the

"Background Information"). I agree to provide the Facility with the Background Information for the Facility's review prior to my acceptance by the Facility.

3. **Policies, procedures, regulations:** I agree to conform to all applicable Facility policies, procedures, and regulations, and such other requirements and restrictions as may be mutually specified and agreed upon the Facility Designated Representative and School.
4. **Personal support:** I understand and agree that I am responsible for my own support, maintenance and living quarters while participating in the clinical experience and that I am responsible for my own transportation to and from the facility.
5. **Medical car e:** I understand and agree that I am responsible for my own medical care needs. I understand that Facility will provide access to emergency medical services should the need arise while I am participating in the Training Experience. However, I understand and agree that I am fully responsible for all costs related to general medical or emergency care, and that Facility shall assume no cost or financial liability for providing such care.
6. **Training:** I acknowledge that I have received training in blood and body fluid standard precautions consistent with the guidelines published by the U.S. Centers for Disease Control and Prevention. Documentation of such training shall be provided prior to beginning my Internship Program.
7. **Academic credit:** I acknowledge that I will receive academic credit for the Training Experience provided at Facility and that I will not be considered an employee of Facility or School, nor shall I receive compensation from either the Facility or School. I further acknowledge that I am neither eligible for nor entitled to workers' compensation benefits under Facility's or School's coverage based upon my participation in Program. I further acknowledge that I will not be provided any benefit plans, health insurance coverage, or medical care based upon my participation in this Program.
8. **Right to participate:** I understand that Facility may suspend my right to participate in the Training Experience, if, in its sole judgment and discretion, my conduct or attitude threatens the health, safety or welfare of any patients , invitees, or employees at Facility or the confidentiality of any information relating to such persons, either as individuals or collectively. I further understand that this action shall be taken by facility only on a temporary basis until after consultation with School. The consultation shall include an attempt to resolve the suspension, but the final decision regarding my continued participation in the Program at Facility is vested in Facility.
9. **Discrimination:** I agree to comply with discrimination regulations and shall not discriminate against any person because of race, color, religion, sex, marital status, sexual orientation, national origin, age, physical handicap, or medical condition as provided by law.
10. **Suspension of use:** I further understand that Facility has the right to suspend use of their facilities in connection with this Training Experience should their facilities be partially damaged or destroyed and such damage is sufficient to render the facilities untenable or unusable for their purpose while not entirely or substantially destroyed.
11. **Confidentiality:** I recognize that medical records, patient care information, personnel information, reports to regulatory agencies, conversations between or among any healthcare professionals are considered privileged and should be treated with utmost confidentiality. I further understand that if

it is determined that a break in confidentiality has occurred as result of my action, I can be held liable for damages that result from such a breach.

I have read the foregoing information and I understand and agree to the terms therein. I recognize that as consideration for agreeing to said terms Facility will permit me to participate in the Training Experience at Facility.

Program: □ PBT □ MLT

Print Student Full Name: Date:

Student Signature: Student ID Number:

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

STUDENT HANDBOOK AGREEMENT

John N. Harms Center, Scottsbluff

After thoroughly reading and familiarizing yourself with the Phlebotomy and Medical laboratory Technician Student Handbook, policies and procedures read and initial each of the following statements.

Student Initials	Statements
	I have read and understand the information provided in this handbook and understand the policies and procedures stated within. I understand that if I cannot support and abide by these policies and procedures, it may be in my best interest to seek another program in which to develop my technical skills.
	I have had an opportunity to ask questions about this material and have had those questions answered to my satisfaction.
	I have read the Essential functions of a PBT and/or MLT Student and understand that if I have difficulty in any of these areas, I may not be successful in passing the Program.
	I have been informed of the amount of clinical time required to complete the clinical practicum requirements to successfully complete the PBT and/or MLT Program.
	1 have read the "Safety & Blood borne Pathogen Policy and Applications" in this Student Handbook. I have been informed that biological specimens and blood products utilized in student lab and clinical rotations may possess the potential of transmitting infectious diseases such as hepatitis and acquired immunodeficiency syndrome (AIDS). I understand that even though diagnostic products are tested for HIV antibodies and Hepatitis B surface antigen (HBsAg), that no known test can offer 100% assurance that products derived from human blood will not transmit disease. I understand that I will be taught the proper way to handle patient specimens and reagents prepared from biological materials (Standard / Universal Precautions) to decrease the risk of exposure and I agree to abide by them.
	I understand that the college does not provide healthcare insurance. I have been advised to carry medical insurance and acknowledge that my health and accident insurance and/or expenses are my responsibility.
	I understand that I must submit proof of all immunizations required by MLS Program.
	I understand that a failure to follow any of these policies may result in my dismissal from the PBT and/or MLT Program.

I agree that while enrolled in the PBT and/or MLT program I will treat my studies, labs, and clinical practicum as an employee would treat job responsibilities, recognizing that my instructor assumes the role of my supervisor. I will attempt to learn not only the technical skills required of a phlebotomist, medical laboratory assistant and/or medical laboratory technician but will also strive to develop professional behaviors and attitudes.

Program: □ PBT □ MLT

Print Student Full Name: Date:

Student Signature: Student ID Number:

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

HEALTH HISTORY QUESTIONAIRE

John N. Harms Center, Scottsbluff

To be completed by PBT and MLT Student

Student Name:		
Student ID Number:	Age :	Date of Birth :
Address:		
Home Phone:	Cell Phone:	Email:
In Case of Emergency Notify :		
Name:	Name:	Physician:
Relationship :	Relationship:	Telephone :
Home or Cell Phone No:	Home or Cell Phone No:	Hospital/Clinic:

Do you have, or have you ever had, the following:

Yes	No	Unsure		Yes	No	Unsure	
0	0	0	Rheumatic fever	0	0	0	Varicose Veins
0	0	0	Heart murmur	0	0	0	Stomach/Liver/Intestinal trouble
0	0	0	Swollen or painful joints	0	0	0	Gall Bladder/Gall Stone trouble
0	0	0	Frequent/Severe headaches	0	0	0	Jaundice or Hepatitis
0	0	0	Dizziness or fainting spells	0	0	0	Reaction to serum drugs/medicine/latex
0	0	0	Eye Trouble/Corrective lenses	0	0	0	Broken bones
0	0	0	Color blindness	0	0	0	Tumor, growth, cyst, cancer
0	0	0	Ear, Nose, Throat trouble	0	0	0	Rupture or hernia
0	0	0	Hearing loss or hearing aid	0	0	0	Frequent or painful urination
0	0	0	Alcohol abuse	0	0	0	Kidney stones or blood in urine
0	0	0	Drug abuse	0	0	0	Sugar or albumin in urine

0	0	0	Hay Fever/Sinusitis/Colds	0	0	0	Diabetes
0	0	0	Animal allergy	0	0	0	VD/Syphilis/Gonorrhea

0	0	0	Head injury	0	0	0	Recent gain or loss of weight
0	0	0	Skin disease	0	0	0	Arthritis/Rheumatism/Bursitis
0	0	0	Thyroid trouble	0	0	0	Bone, joint or other deformity
0	0	0	Tuberculosis	0	0	0	Recurrent back pain
0	0	0	Coughed up blood	0	0	0	Brace or back support
0	0	0	Asthma	0	0	0	Tricker locked knee
0	0	0	Shortness of breath	0	0	0	Foot trouble
0	0	0	Pain or pressure in chest	0	0	0	Any disease of glands
0	0	0	Chronic cough	0	0	0	Depression or excessive worry
0	0	0	Palpitation or pounding heart	0	0	0	Loss of memory or amnesia
0	0	0	Heart trouble	0	0	0	Nervous or mental disorder
0	0	0	High or low blood pressure	0	0	0	Chickenpox
0	0	0	Neuritis	0	0	0	Paralysis (include infantile)
0	0	0	Epilepsy or seizures				

Explain YES answers as necessary:

Current Medications:

In an emergency, I authorize the WNCC personnel in charge to use their discretion regarding the Colleges emergency procedures.

Program: □ PBT □ MLT

Print Student Full Name: Date:

Student Signature: Student ID Number:

Students under age of 18

Print Parent or Guardian Full Name: Date:

Parent or Guardian Signature:

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

LETTER OF RECOMMENDATION

John N. Harms Center, Scottsbluff

Applicant Instructions: Three references are required to complete your application. It is recommended that you consider requesting references from individuals who know you well and can comment on your suitability and preparation for a health care career and/or your academic preparation (academic instructors or work related contacts). Complete the Waiver of Access Section. If you check DO, you will not be able to view the letter submitted on your behalf. If you check DO NOT, you will have the right to inspect your student records ONLY if you are accepted and enrolled at the PBT and/or MLT program. Complete the applicant's section of the form, print it out, and send to your recommender. Ask your recommender to complete the form, attach their letter of recommendation and mail it to the following address:

Western Nebraska Community College
Attention: Dr. Mwafaq Haji
Medical Laboratory Science Program
2620 College Park, Scottsbluff, NE 69361

Section I: **APPLICANT INFORMATION**

Last Name: **First Name:**

Phone Number: **Email Address:**

Program: o **PBT** o **MLT**

Section II: **WAIVER OF ACCESS TO LETTER OF RECOMMENDATION**

Under the Family Education Rights and Privacy Act, enrolled students have the right to inspect their files upon request. In order to inform the person, you have requested to write a letter of recommendation whether the letter will be held in confidence or if the letter will be open to your inspection, please check one of the following statements. Waiving your rights to see this letter of recommendation is not a requirement for admission.

] I hereby **DO** waive my rights to access this letter of recommendation.

] I hereby **DO NOT** waive my rights to access this letter of recommendation.

Student Signature: **Date:**

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

LETTER OF RECOMMENDATION

John N. Harms Center, Scottsbluff

Print Student Full Name: **Program: □ PBT o MLT**

Dear Evaluator/Recommender:

The above named applicant if applying for admission to the Western Nebraska Community College, Medical Laboratory Science Program to pursue a course of study, which will lead to certification as Phlebotomy Technician (PBT) and/or Medical Laboratory Technician (MLT). The program seeks individuals who have the potential for success in a rigorous education program and possess the personal attributes required to become a competent laboratory professional. Please provide reference information regarding this candidate's academic traits and/or work habits on this evaluation form. Please attach your letter of recommendation, preferably printed on institutional letterhead. In your letter of recommendation, please provide any additional narrative comments that may be of help in determining the success of this applicant in the PBT, and/or MLT Program and provide comments about the applicant's strengths, weaknesses, developing maturity, problem solving ability, originality, unique skills, cultural sensitivity, attributes, or future potential. Your candid evaluation of the applicant will be of significant value and is appreciated. The applicant has also completed the Waiver of Access Section in this form, which allows her or him to waive the right to review, she or he may request to review the recommendation once accepted and enrolled to the program. After completing the evaluation, please seal it in an enveloped the applicant has provided and return it to the address on the envelope. Your time and cooperation is very much appreciated.

Section III: EVALUATOR/RECOMMEDER INFORMATION

Last Name: **First Name:**

Phone Number: Email Address:

Title/Positi on: **Organization/Institution:**

Mailing Address:

How long have you known the student/applicant?

In what capacity have you been associated with this applicant?

How well do you know the applicant? [ ] Very well [ ] somewhat [] Not very well

How comfortable would you be with this student/applicant performing medical laboratory procedures/tests on you or a loved one? [] Very comfortable [] somewhat comfortable [] Somewhat uncomfortable [] *Very* uncomfortable [] Don't Know

OVERALL CONSIDERATION

I consider this student/ applicant ' s overall prospects for success as a PBT and/or MLT student at WNCC to be :

Recommend without Reservation 5.0	4.5	4.0	3.5	Recommend with Reservation 3.0	2.5	2.0	1.5	DO NOT Recommend 1.0

Western Nebraska Community College

Health Science Division

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For each of the following characteristics, please assign 1 value of 1-5 with 5 representing t e most favorable value.

Dependability/ Punctuality	1	Y2	Y3	4	rs	T No basis to Judge
Maintain a clean and neat appearance	Yl	Y2	Y3	Y4	rs	r No basis to judge
Leadership ability	rl	Yz	Y3	Y4	rs	Y No ba$is to judge
Intellectual ability	r1	r2	Y3	Y4	rs	r No basis to jud ge
initiative	rl	Y2	r3	"r4	rS	No basis to judge
Manual dexterity	r1	Y2	r3	Y4	rs	r No basis to judge
Acceptance of constructive cri tic ism	r1	Y2	Y3	r 4	rs	Y No b sls to Ju dge
Acceptance of responsibility	Y1	rz	r3	Y4	rs	r No basis to judge
Emotional maturity	Yl	Y2	r3	4	rs	r No basis to judge
Honesty and integrity	r1	r2	r3	r4	rs	r No basis to judge
Receptive to change	ri	2	3	Y4	rs	r No basis to Jud ge
Ability to work as a team player	r1	Y2	r3	Y4	rs	r No basis to judge
Ability to work under pressure	r1	r z.	Y3	H	rs	Y No basis to Judge
Communication skills (written)	r1	Y2	Y3	Y4	rs	r No basis to judge
Communication skill s {oral)	Yl	Y2	Y3	Y'4	)"S	'Y' No basis to Ju dge
Decision making skills	r1	r2	r3	Y4	rs	r No basis to judge
At tent ion to cl tail	Y.1	Y2	Y3	Y4	rs	T No basis to Judge
Computer skills	Yl	Y2	r3	Y4	rs	r No basis to judge

Evaluator/ Recommender Signature: pate:

Please mail Letter of Recommendation and completed forms to the following address:

Western Nebraska Community College
Attention: Dr. Mwafaq Haji
Medical Laboratory Science Program
2620 College Park
Scottsbluff, NE 69361

Western Nebraska Community College

Health Science Division

Medical Laboratory Science Programs {PBT, MLT)

Student Immunization Panel

John N. Harms Center, Scottsbluff

This form must be presented to the Clinical Laboratory. Regional West Laboratory Services is offering a Student Immunization Panel which includes the following tests:

- Varicella Zoster lgG
- Mumps lgG
- Rubella lgG
- Rubeola (Measles) lgG
- Hepatitis Surface Antibody
- Quantiferon Gold TB

These tests will be performed for Western Nebraska Community College Health Sciences Students at a discounted rate ($110.95 (subject to change)). To have this panel performed you must go to Regional West Laboratory Services to be drawn. Their locations are listed below:

Regional West Medical Center

4021 Avenue B, Scottsbluff, NE 69361

Hours: 8:00 AM to 5:00 PM, Monday through Friday

North Plaza Laboratory: (308) 630-1668 or South Plaza Laboratory: (308) 630-2115

Students must pay cash or check at the time of service. A copy of the results will be sent to Western Nebraska Community College and to the student's home address. You must read and complete the following:

NOTE TO RECIPIENT OF MEDICAL RECORDS. The patient's medical record is privileged information which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

, l_____ _____ __ _ ___ __ _ ___ ___ _ Born _ _ ____ _____

(Patient's Name) (Date of Birth)

(Mailing Address) {City) {State) {Zip Code)

I authorize Regional West Medical Laboratory Services to release to the party listed below my laboratory test results for the Student Immunization Panel. My medical records may be inspected by and/or copies may be released to:

Western Nebraska Community College
Attention: Dr. Mwafaq Haji
Medical Laboratory Science Program
2620 College Park, Scottsbluff, NE69361

Print Student Full Name: **Date:**

Student Signature:

**Students under age of 18*

Print Parent or Guardian Full Name:	**Date:**
Parent or Guardian Signature:	

Verified CREDENTIALS

Western Nebraska Community College

Western Nebraska Community College has collaborated with Verified Credentials to manage your program requirements including the following:

- **Background Report**

To access Verified Credentials - Student go to the following Website:

http://scholar. verifiedcredentials.com/?organization=wncc

How It Works:

1. **Enter code for the program you will be attending** located above the "Get Started!" button on the right side of the page

Scottsbluff - Lab

BBKWK-26967

2. Create an account
3. Enter all required information
4. Provide supporting documentation
5. Track your progress
6. Information will automatically be shared with your school

If you have any questions, our Client Services Team is ready to assist you. Please call us at 800.938.6090 or email us at ClientServic es@verif iedcredentials.com .