PARAMEDIC CERTIFICATE PROGRAM
FOR REGISTERED NURSES

EMS 2288 Paramedic Theory for RNs conforms to the National Paramedic Education Standards. The program includes intensive classroom education, practical skills lab, and hospital and pre-hospital clinical practice on a paramedic unit. Upon successful completion, each candidate will be eligible to sit for the NREMT paramedic written and practical examination, and subsequently will be eligible for Ohio certification as a paramedic.

This unique program is designed specifically to prepare the experienced Registered Nurse to function in the pre-hospital setting, e.g., fire and EMS departments, critical care transport vehicles, aeromedical services, EMS coordination and education. Past training, education, and hospital and/or pre-hospital critical care work experience allows the Registered Nurse to complete the program in approximately 15 weeks.

Enrollment is limited to the Registered Nurse, Physician, and Physician's Assistant with extensive emergency and/or critical care experience, who is certified as an EMT-Basic in Ohio and currently maintains a BLS-CPR card, ACLS provider or instructor card, PALS provider or instructor card. PHTLS, BTLS, or TNCC is desirable. In addition, each applicant must have at least two years' experience in a critical care setting (e.g. ED, CCU, ICU, MICU, SICU, Critical Care Transport, etc.

Entrance Requirements
Students must first apply to the College by completing the application online at https://emas.clarkstate.edu/Apply.aspx.

Prior to entering EMS 2288, the student must meet the following entrance requirements:

1. Complete the Program Entrance Request form. (form follows)
2. Provide proof of current Ohio EMT-Basic certification. (copy of card)
3. Provide proof of current CPR provider certification; ACLS provider; PALS provider, PHTLS or BTLS provider. (copies of cards)
4. Provide proof of licensure for RN, nurse practitioner, physician's assistant, or respiratory therapist.
5. Complete physical exam, history, and required immunizations. (forms and instructions follow)
6. Complete education, training, and work experience form. (form follows)
7. Obtain criminal background check (instructions follow)

Students must submit 1-6 above to the EMS Program Coordinator. Students must request that item 7 be sent directly to the EMS Program Director as indicated on the directions that follow. Once the above requirements have been satisfactorily met, the EMS Program Coordinator will authorize the student's enrollment into the course.

Certification Exam and Employment:
In order to practice as a Paramedic in Ohio, an individual must pass the State's Certification exam. In order to take the certification exam, the individual must have certification as an EMT Basic in Ohio, demonstrate recent successful completion of a Paramedic training program and submit an application to take the exam. All applicants will be asked if they have been convicted of specific crimes and if they have been deemed mentally incompetent by a court of law. If the applicant answers yes, an evaluation will be completed by the State Division of EMS to determine if the applicant will be issued a certificate to practice. All students shall be aware that a criminal record may jeopardize their ability to obtain certification and employment.

Additional Requirements
- Students are required to have professional liability insurance. The cost of this insurance is added to registration fees.

Contact Information
For additional information, please contact EMS Program Coordinator at 937-328-6059

Revised 7/07, 4/09, 9/12, 10/16

Health, Human and Public Services Division
EMS Technology

EMERGENCY MEDICAL SERVICES
Program Entrance Request
Paramedic Program for RNs

OPDS OH 308

Disclaimer: Complete this form does not guarantee entry into the program. Specific requirements must be met prior to being accepted. The student will be accepted upon submission and proof of course prerequisites and required documents. Refer to the entrance requirements sheet.

PART 1: Personal Information *(This information is considered confidential.)*

Applicant Name:

____

First Name Middle Initial Last Name

Home Address:

____

Street and Number City State Zip Code
County

Driver's License Number: ___________________________ Home Phone: _______________________________

Business Phone: __________________________________

Age: _____________ Date of Birth: ___________________ Clark State ID or last 4 digits of SS # ____________

PART II: General background information *(This information is considered confidential.)*

Emergency Medical Service Association: _________________________[ ] Full-time Paid [ ] Part-time [ ] Volunteer

Address: ____ Supervisor: ____________________________

Primary Occupation: ____ Employer: _____________________________

Highest level of formal education: ____

Ohio EMT Certification Number and Level of Training: ____

National Registry EMT: [ ] Yes [ ] No If yes, # ____

Have you ever been convicted of a felony? [ ] Yes [ ] No

Do you have a disability for which you need special accommodations? (Optional to answer) [ ] Yes* [ ] No
*If yes, students are strongly encouraged to contact the College's Office of Accessibility several weeks before enrolling in classes.

I certify that the above information is correct and complete to the best of my knowledge and belief. I understand and agree that misrepresentation, falsification, or omission of material fact may be cause for rejection of my application or for termination after acceptance into the program.

Applicant's Signature ____ Date of Application: ________________

Health, Human and Public Services Division
EMS Technology
570 E. Leffel Lane
Springfield, Ohio 45501
EMS Office: 937.328.6059
Fax: 937.328.8084

EMERGENCY MEDICAL SERVICES
Program Entrance Request
Paramedic Program for RNs

OPDS OH 308

Education-Licensure/Certifications – Work-Experience Form

Name ____ Student ID or last 4 digits of SS# ________________

Address

____

City, State, Zip Code

____

Education Background

____
____
____
____

Emergency Critical Care Background

____
____
____
____

Licensures/Certifications (include numbers)
e.g. RN License, CEN, CCRN, EMT (other)

____
____
____

Formal Degrees/Education
(include major course of study)

____
____
____

Describe background and/or experience that you feel qualifies you for the RN/ to Paramedic Program:

____
____
____
____
____

____
Acceptance Signature
EMS Program Director

____
Date

Detailed Explanation of Required Medical Documentation

Prior to entering a health technology program at Clark State, there are specific clinical and health- related requirements that must be met. Please read the following details carefully, as some of these requirements can become confusing, depending on your individual situation. You may want to take this information with you when you go for your physical, immunizations or blood titers, so that your health care provider understands exactly what needs to be done. If you do not have a family physician or have a high insurance co-pay or deductible, refer to the enclosed table of healthcare providers for other possible resources.

1. **Physical Examination** – A physician or nurse practitioner needs to complete and sign the physical examination form located in this packet. When getting a physical, take with you proof of a current TB test, as some physicians will not sign the form without it. Please be certain that the physician has answered the last two questions on the exam form. These questions are: **"Is this person capable of lifting 25 pounds?" and "Is this person free from communicable diseases?"** If you have already had a physical within the past year (employment, school, OB/Gyn, etc.) copies will be accepted as fulfillment of this requirement.

2. **TB Test/Mantoux** – If you have never had a TB test before or if it has been greater than 13 months since you've had a skin test, you will need to get a two-step TB test. To qualify as a two-step TB test, two separate tests must be given and read one to three weeks apart. (For example, one test is given on 6/1/16, read on 6/3/16 and the second test is given on 6/8/16 and read on 6/10/16). We will need copies of the results/readings of each of these two tests.

   If you have never received a two-step TB test, but you receive yearly one-step TB tests, you will need to submit proof of your last two annual tests and your last test must have been done within the past year. (For example, a one-step is given on 6/1/15 and another one-step is given a year later on 6/20/16). We will need copies of each of these tests.

   In addition, it is your responsibility to update your TB requirements yearly. If your TB test expires while you are a health technology student at Clark State, you will need to update your test and submit documentation to the Clinical Records Specialist.

   - **T-Spot or Quantiferon** – negative blood assay will also be accepted as fulfillment of this requirement.
   - **Chest X-ray** – A negative chest x-ray is required only if your TB test comes back as *positive*. If you have had a *positive* reaction in the past, you must submit proof of a *negative* chest x-ray, taken after your skin test converted to positive, followed by yearly "TB Questionnaires" which screen for symptoms. You may obtain an authorization slip for a chest x-ray from the Clark County Combined Health District (including Greene or Logan County students), which will allow you to get an x-ray at Springfield Regional Imaging Center, (see enclosed table) free of charge. TB Questionnaires are available through the Clark County Combined Health District or through the Clark State Health Clinic.

3. **MMR (Rubella, Rubeola and Mumps Immunization or Titers)** – You will need to submit documentation of two MMR vaccines given at least one month apart (after the age of 12 months) or laboratory evidence (positive titers) of having immunity to Rubella, Rubeola and Mumps. Titers are blood tests that show immunity to a specific disease and normally require a physician's order to be done.

   If any of your Rubella, Rubeola or Mumps titers come back as *negative*, you must get the MMR vaccine anyway, as a negative titer is an indication that you are not protected against one or all of these diseases. Obtain a copy of the two immunizations or your lab reports. Your lab report must show your results **PLUS** the "reference/standard range" for that specific test. Lab reports without the reference range (or something comparable that clearly indicates if the titer is positive or negative) will not be accepted. (FYI-Rubella titers are routinely drawn during pregnancy and results may be available from your obstetrician.) **NOTE-If the MMR vaccine is needed, complete your TB test(s) first.**

4. **MMR (Rubella, Rubeola and Mumps Immunization <u>or</u> Titers)** – You will need to submit documentation of two MMR vaccines given at least one month apart (after the age of 12 months) or laboratory evidence (positive titers) of having immunity to Rubella, Rubeola and Mumps. Titers are blood tests that show immunity to a specific disease and normally require a physician's order to be done.

   If any of your Rubella, Rubeola <u>or</u> Mumps titers come back as *negative*, you <u>must</u> get the MMR vaccine anyway, as a negative titer is an indication that you are not protected against one or all of these diseases. Obtain a copy of the two immunizations or your lab reports. Your lab report must show your results **<u>PLUS</u>** the "reference/standard range" for that specific test. Lab reports without the reference range (or something comparable that clearly indicates if the titer is positive or negative) will not be accepted. (FYI-Rubella titers are routinely drawn during pregnancy and results may be available from your obstetrician.) **NOTE-If the MMR vaccine is needed, complete your TB test(s) <u>first</u>.**

5. **Chicken Pox (Immunizations <u>or</u> Positive Varicella Titer)** – You must have had two Varicella vaccines, given at least 1 month apart or a *positive* Varicella titer. **History of chicken pox does not satisfy this requirement.** If your Varicella titer comes back as *negative* (an indication that you are not protected against this disease), you <u>must</u> get two Varicella vaccines. Obtain a photocopy of your two immunizations or your Varicella titer lab report. Your lab report must show your results **<u>PLUS</u>** the "reference/standard range" for that specific test. Lab reports without the reference range (or something comparable that clearly indicates if the titer is positive or negative) will not be accepted. **NOTE – If the Varicella vaccine is needed, complete your TB test <u>first</u>.**

6. **Tetanus/Diphtheria/Pertussis Booster(s)** – Students must submit proof of a one-time dose of the Pertussis vaccine (Tdap), given at age 11 or older. If the vaccine was given less than 10 years ago, nothing else is needed, other than proper documentation of the Tdap. If the Tdap was given greater than 10 years ago, an additional Tetanus/Diphtheria (Td) booster is required. You would then need to submit documentation of both the Tdap and the Td.

   Tetanus shots are frequently given in the ER or Urgent Care for injuries that require stitches. If this pertains to you, you will need to obtain a copy of your records from the health care facility where you received treatment or you may choose to repeat the immunization.

7. **Hepatitis B or AB (Immunizations <u>or</u> a Positive Titer) –**

Medical Laboratory Technology and Medical Assisting – **REQUIRED**
All other Health Technology programs – **STRONGLY ENCOURAGED** (must sign consent / declination form)

The Hepatitis B vaccine is a series of 3 shots, given at 1 month, 2 months and 6 months intervals. If you choose to have a Hepatitis B titer drawn, results are more accurate if drawn 1 month after the series is completed. Your lab report must show your results **<u>PLUS</u>** the "reference/standard range" for that specific test. Lab reports without the reference range (or something comparable that clearly indicates if the titer is positive or negative) will not be accepted.

8. **Influenza (Flu) Vaccine** – Students must submit proof of a current flu shot (dated after August 1 but before October 31, for those students beginning a health technology program in the fall semester). The Health Department offers flu shots on campus each fall, but you may receive it from any provider. You will need to update your flu shot <u>yearly</u> while in a health technology program and submit documentation to the appropriate person. (Students doing clinicals during the summer may not be required to have a flu shot. If this applies to you, please check with your instructor.)

It is your responsibility to make a copy of all documentation for your records, <u>before</u> submitting, and keep in a safe place. Future employers will need this information, too.

(Revised 4/16, 10/16)

Personal Medical History

Program: ☐ RN ☐ LPN ☐ EMT-P ☐ MLT ☐ MAS ☐ PTA ☐ Faculty ☐ Other

☐Miss
☐Mr.
☐Mrs. ____
Last First Middle Maiden

Date of birth__________________Height___________Weight___________Phone number(   )______________

Local address____
Street address City State Zip

Parent, guardian, or nearest relative____
Name Relationship

____(   )______________
Street address City State Zip Phone number

Person to notify in case of emergency______________________________(   )______________
Name Home Phone Number

____(   )______________
Street address City State Zip Work Phone number

Family physician____(   )______________
Name Street address Phone number

---

1. General Health Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. For what reasons have you been hospitalized during the last five years?

____

3. Are you under a doctor's care at the present time? ☐ Yes ☐ No If yes, please explain.

____

4. List any medications you are taking at the present time

____

5. Have you had any allergic reactions to medications, foods, latex, or insect bites? ☐ Yes ☐ No If yes, please explain.

____

6. List any physical impairments or restrictions you may have (paralysis, difficulty hearing, vision, speech, etc.)

____

Personal Medical History (continued)

7. Have YOU ever had any of the following? Please circle yes or no next to each below.

Food Allergies	YES	NO	Eye/Visual Impairment	YES	NO	Liver Problems/Hepatitis	YES	NO
Allergy to Wasp/Bee Stings	YES	NO	Ear/Hearing Problems	YES	NO	Mononucleosis	YES	NO
Head Injuries/Concussions	YES	NO	Nose/Throat/Sinus	YES	NO	Kidney/Bladder Problems	YES	NO
Seizures	YES	NO	Thyroid/Endocrine Problems	YES	NO	Women: Menstrual Problems	YES	NO
Recurrent Headaches	YES	NO	Diabetes	YES	NO	Chance of being pregnant	YES	NO
Dizziness	YES	NO	Cancer	YES	NO	Disease/Injury of Joints	YES	NO
Weakness/Paralysis/Disability	YES	NO	Lung/Respiratory Problems	YES	NO	Arm/Shoulder/Hand Injury	YES	NO
Insomnia/Sleep Disorder	YES	NO	Hay Fever/Asthma	YES	NO	Leg/Knee/Foot Injury	YES	NO
Depression	YES	NO	Pneumonia	YES	NO	Fractures/Broken Bones	YES	NO
Panic Attacks/Anxiety	YES	NO	Tuberculosis	YES	NO	Back Problems/Injuries	YES	NO
Emotional Problems	YES	NO	Heart Disease	YES	NO	Surgeries:		
Eating Disorders	YES	NO	Heart Murmur	YES	NO	Appendectomy	YES	NO
Recent Weight Change	YES	NO	Skipping/Racing Beats	YES	NO	Tonsillectomy	YES	NO
ADD/ADHD	YES	NO	Elevated Blood Pressure	YES	NO	Hernia Repair	YES	NO
Cigarettes: # packs/day, # of years	YES	NO	Anemia/Sickle Cell	YES	NO	Other:		
Alcohol/Substance Abuse	YES	NO	Bleeding Disorders	YES	NO			
Dental Problems	YES	NO	Stomach/Intestinal Problems	YES	NO			

Please comment on significant "YES" answers: ______________________________

____

____

Have you had any illness, injury or hospitalization other than what is already noted? ☐ No ☐ Yes, please explain

____

____

____

____

Signature: ______________________________ Date: ______________

Complete and return this form to the Clinical Records Specialist in the Health, Human and Public Services Division, Applied Science Center.

Physician's Exam Form

Program: ❑ RN ❑ LPN ❑ EMT-P ❑ MLT ❑ MAS ❑ PTA ❑ STNA ❑ Faculty ❑ Other

Name____Sex______Age______Height__________Weight_______

Blood pressure______________Pulse______________Respirations______________Vision rt. 20/_________lf. 20/_____

Allergies____

Are there any abnormalities of the following: Comments:

1. Head, neck, face, and scalp ❑ Yes ❑ No ____
2. Nose and sinuses ❑ Yes ❑ No ____
3. Mouth, teeth, gingivae, and throat ❑ Yes ❑ No ____
4. Ears ❑ Yes ❑ No ____
5. Eyes ❑ Yes ❑ No ____
6. Lungs, chest, and breasts ❑ Yes ❑ No ____
7. Heart and vascular system ❑ Yes ❑ No ____
8. Abdomen and viscera (include hernia) ❑ Yes ❑ No ____
9. Ano-rectal and pilonidal ❑ Yes ❑ No ____
10. Endocrine system ❑ Yes ❑ No ____
11. Genito-urinary system ❑ Yes ❑ No ____
12. Upper extremities ❑ Yes ❑ No ____
13. Lower extremities ❑ Yes ❑ No ____
14. Spine, other musculo-skeletal ❑ Yes ❑ No ____
15. Skin and lymphatics ❑ Yes ❑ No ____
16. Neurologic system ❑ Yes ❑ No ____

*****MUST COMPLETE*****

Is this person physically capable of lifting 25 pounds? ■ Yes ■ No

Is this person free from communicable diseases? ■ Yes ■ No

Examination Date ____

Examining Physician or Nurse Practitioner Signature ____

Address ____

____

Complete and return this form to the Clinical Records Specialist in the Health, Human and Public Services Division, Applied Science Center, P.O. Box 570, Springfield, OH 45501.

4/2016

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 What is hepatitis B?

Hepatitis B is a serious infection that affects the liver. It is caused by the hepatitis B virus.

- In 2009, about 38,000 people became infected with hepatitis B.
- Each year about 2,000 to 4,000 people die in the United States from cirrhosis or liver cancer caused by hepatitis B.

Hepatitis B can cause:

Acute (short-term) illness. This can lead to:

- loss of appetite
- diarrhea and vomiting
- tiredness
- jaundice (yellow skin or eyes)
- pain in muscles, joints, and stomach

Acute illness, with symptoms, is more common among adults. Children who become infected usually do not have symptoms.

Chronic (long-term) infection. Some people go on to develop chronic hepatitis B infection. Most of them do not have symptoms, but the infection is still very serious, and can lead to:

- liver damage (cirrhosis)
- liver cancer
- death

Chronic infection is more common among infants and children than among adults. People who are chronically infected can spread hepatitis B virus to others, even if they don't look or feel sick. Up to 1.4 million people in the United States may have chronic hepatitis B infection.

Hepatitis B virus is easily spread through contact with the blood or other body fluids of an infected person. People can also be infected from contact with a contaminated object, where the virus can live for up to 7 days.

- A baby whose mother is infected can be infected at birth;
- Children, adolescents, and adults can become infected by:
  - contact with blood and body fluids through breaks in the skin such as bites, cuts, or sores;
  - contact with objects that have blood or body fluids on them such as toothbrushes, razors, or monitoring and treatment devices for diabetes;
  - having unprotected sex with an infected person;
  - sharing needles when injecting drugs;
  - being stuck with a used needle.

2 Hepatitis B vaccine: Why get vaccinated?

Hepatitis B vaccine can prevent hepatitis B, and the serious consequences of hepatitis B infection, including liver cancer and cirrhosis.

Hepatitis B vaccine may be given by itself or in the same shot with other vaccines.

Routine hepatitis B vaccination was recommended for some U.S. adults and children beginning in 1982, and for all children in 1991. Since 1990, new hepatitis B infections among children and adolescents have dropped by more than 95%—and by 75% in other age groups.

Vaccination gives long-term protection from hepatitis B infection, possibly lifelong.

3 Who should get hepatitis B vaccine and when?

Children and adolescents

- Babies normally get 3 doses of hepatitis B vaccine:

1st Dose:	Birth
2nd Dose:	1-2 months of age
3rd Dose:	6-18 months of age

  Some babies might get 4 doses, for example, if a combination vaccine containing hepatitis B is used. (This is a single shot containing several vaccines.) The extra dose is not harmful.

- Anyone through 18 years of age who didn't get the vaccine when they were younger should also be vaccinated.

Adults

- All unvaccinated adults at risk for hepatitis B infection should be vaccinated. This includes:
  - sex partners of people infected with hepatitis B,
  - men who have sex with men,
  - people who inject street drugs,
  - people with more than one sex partner,
  - people with chronic liver or kidney disease,
  - people under 60 years of age with diabetes,
  - people with jobs that expose them to human blood or other body fluids,

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- household contacts of people infected with hepatitis B,
- residents and staff in institutions for the developmentally disabled,
- kidney dialysis patients,
- people who travel to countries where hepatitis B is common,
- people with HIV infection.

- Other people may be encouraged by their doctor to get hepatitis B vaccine; for example, adults 60 and older with diabetes. Anyone else who wants to be protected from hepatitis B infection may get the vaccine.
- Pregnant women who are at risk for one of the reasons stated above should be vaccinated. Other pregnant women who want protection may be vaccinated.

Adults getting hepatitis B vaccine should get 3 doses—with the second dose given 4 weeks after the first and the third dose 5 months after the second. Your doctor can tell you about other dosing schedules that might be used in certain circumstances.

4 Who should not get hepatitis B vaccine?

- Anyone with a life-threatening allergy to yeast, or to any other component of the vaccine, should not get hepatitis B vaccine. Tell your doctor if you have any severe allergies.
- Anyone who has had a life-threatening allergic reaction to a previous dose of hepatitis B vaccine should not get another dose.
- Anyone who is moderately or severely ill when a dose of vaccine is scheduled should probably wait until they recover before getting the vaccine.

Your doctor can give you more information about these precautions.

Note: You might be asked to wait 28 days before donating blood after getting hepatitis B vaccine. This is because the screening test could mistake vaccine in the bloodstream (which is not infectious) for hepatitis B infection.

5 What are the risks from hepatitis B vaccine?

Hepatitis B is a very safe vaccine. Most people do not have any problems with it.

The vaccine contains non-infectious material, and cannot cause hepatitis B infection.

Some mild problems have been reported:

- Soreness where the shot was given (up to about 1 person in 4).
- Temperature of 99.9°F or higher (up to about 1 person in 15).

Severe problems are extremely rare. Severe allergic reactions are believed to occur about once in 1.1 million doses.

A vaccine, like any medicine, could cause a serious reaction. But the risk of a vaccine causing serious harm, or death, is extremely small. More than 100 million people in the United States have been vaccinated with hepatitis B vaccine.

6 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS is only for reporting reactions. They do not give medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**.

8 How can I learn more?

Ask your doctor.

- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Hepatitis B Vaccine

2/2/2012

42 U.S.C. § 300aa-26

Office Use Only

CLARK STATE COMMUNITY COLLEGE

CONSENT OR DECLINATION FORM FOR THE HEPATITIS B VACCINE

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection, a serious disease. I have received information about the Hepatitis B vaccine and I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine and I have decided to **CHOOSE** to receive or complete the Hepatitis B vaccine series.

Signature ____ Date ________________

OR

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection, a serious disease. I have received information about the Hepatitis B vaccine and I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine and I have decided to **DECLINE** the Hepatitis B vaccine for one of the following reasons:

- ☐ I **DECLINE** Hepatitis B vaccine at this time for personal, financial or other reasons.
- ☐ I **DECLINE** the Hepatitis B vaccine because I have already received the vaccine series.

Signature ____ Date ________________

Created 4/15

CLARK COUNTY HEALTHCARE PROVIDERS

(See page 2 for a listing of other Ohio County Health Departments)

CLARK COUNTY HEALTHCARE PROVIDERS	PHYSICALS (In addition, physicals are performed at most Urgent Care Centers on a walk-in basis, but anticipate a higher fee.)	TB TEST 2 step thru current 1 step	CHEST X-RAY Only if + TB skin test	MMR Your second MMR vaccine or proof of + Rubella & Rubeola Titers (Titers require a physician's order, obtain copy of lab report)	Chicken Pox Verbal Hx. of Disease or proof of Vaccine or + Varicella Titer (Titers require a physician's order, obtain copy of lab report)	TETANUS Td or Tdap, within past 10 years	HEP. B If required by your program	IN"FLU"ENZA VACCINE If required by your program or clinical site (current season's vaccine, also available at most pharmacies)
Clark County Combined Health District 529 East Home Rd. Springfield, OH 937-390-5600	No	1 or 2 step	Gives order form to take to SRMC Imaging Center	MMR Vaccine	Varicella Vaccine, series of two	Td or Tdap	series of three	Yes
Community Mercy Occupational Health & Medicine 2501 E. High Street Springfield, OH 937-328-8700, prompt #1, Mon.-Fri. 8-4:30 (by appointment, only) *Vaccines & Titers available from this provider only if your physical is performed by them, as well.	$42 (bring physical form and all shot records to appt.)	*Yes	No	*MMR Vaccine *Rubella Titer *Rubeola Titer	*Varicella Titer only, vaccine not available at this location	*Yes	*Yes	*Yes
Springfield Regional Medical Center, Imaging Center 1343 N. Fountain Blvd. Springfield, OH 937-390-5000	No	No	Free with order from CCCHD. X-rays are read on Thurs. only, so plan accordingly.	No	No	No	No	No
Clark State Community College Health Clinic 570 East Leffel Ln. Springfield, OH 937-328-6042	No	1 or 2 step, while supplies last	No	No	No	No	No	No

Revised 9/12. Prices are subject to change without notice. Please call for current pricing, if this is a concern for you.

COUNTY HEALTH DEPARTMENTS	ADDRESS	PHONE
Champaign County	1512 South US Hwy 68, Suite Q 100, Urbana, OH	(937) 484-1605
Franklin County	280 East Broad Street, 2nd floor, Columbus, OH	(614) 525-3160
Greene County	360 Wilson Dr. Xenia, OH	(937) 374-5600
Logan County	310 S Main Street, Bellefontaine, OH	(937) 592-9040
Madison County	306 Lafayette Street, Suite B, London, OH	(740) 852-3065
Miami County	510 West Water Street, Suite 130, Troy, OH	(937) 573-3500
Montgomery County	1 S Main St # 440, Dayton, OH	(937) 285-6250
Union County	940 London Ave., Suite 1100, Marysville, OH	(937) 642-2053

Health, Human, and Public Services Division
Health Insurance Attestation Form

Health professions students are at risk for exposure to pathogens and infections. It is the student's responsibility to provide payment for the cost of any diagnostic or therapeutic measures recommended as a result of an exposure or injury. The College's affiliation agreements with many facilities where students are assigned for their clinical experiences require students to have health insurance. Therefore, all students in the Medical Laboratory Technology, Registered Nursing, Practical Nursing, Physical Therapist Assistant, and Emergency Medical Services programs at Clark State Community College are required to obtain and maintain adequate health insurance while enrolled in clinical courses.

Students who do not have health insurance may purchase a student policy through a provider of their choosing or through the College's provider, EJ Smith & Associates, Inc., who markets a Student Security Plan underwritten by Transamerica Life Insurance Company. Information about this plan is available on the College's web site at http://www.clarkstate.edu/student-life/health-fitness/student-health-insurance/ and at E. J. Smith's web site www.ejsmith.com. Once on E.J. Smith's web site, select Students > Student Security Plan > and the appropriate academic year plan. Forms to enroll in the plan are also available on this web site.

All students must provide the following information about their health insurance coverage, read and sign this form, and submit along with their medical history, physical and immunizations documentation to the Health, Human, and Public Services Division, Clinical Records Specialist. This information will be kept on file in the student's file. Students will not be permitted to participate in clinical courses until this form is completed, signed and submitted.

Student Name (print): ____

Student's Clark State ID#:

Name of Health Insurance Provider: ____________________________________

Subscriber or Group Number: ____

I, the undersigned, attest that I have health insurance coverage as listed above. I understand that I must maintain health insurance coverage throughout the time that I am enrolled in clinical courses. I further understand that if my health insurance coverage provider changes, I need to complete and sign another form and submit it to the Health, Human and Public Services Division, Clinical Records Specialist to update my student file.

Student Signature:___________________________________Date: _______________

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CLARK STATE COMMUNITY COLLEGE
MEDICAL RECORDS RELEASE FORM

I give Clark State Community College Clinical Records Specialist/Health Clinic Nurse permission to release my medical records related to clinical requirements to any of the health technology instructors or staff, to my assigned clinical sites, as necessary, or to myself.

____

Student's Name (printed)

____

Student's Signature

____

Date

Clark State Community College – Emergency Medical Services
Criminal Records Check Policy

Health care providers are entrusted with the health, safety and welfare of patients; have access to controlled substances and confidential information; and operate in settings that require the exercise of good judgment and ethical behavior. Clinical facilities are increasingly required by accreditation agencies, such as The Joint Commission (TJC), to conduct background checks on individuals who provide services within the facility and especially those who supervise care and render treatment. In addition, the Ohio Revised Code requires a criminal records check for all prospective employees for positions where the individual will be caring for older adults or children.

Clinical learning experiences are an essential element of the curriculum of health care programs. All students enrolled in Clark State's health care programs must successfully complete a criminal records check as a criterion for participating in clinical courses. Participation in clinical courses is required for progression and completion of health care programs.

The check must include fingerprinting and must be completed by the Ohio Bureau of Criminal Identification and Investigation (BCII). If the student has not been a resident of Ohio continuously for the previous five years, a Federal Bureau of Investigation report is also required. The criminal records check **must be completed within three months of the student's entry into the first clinical course in the program.** Agencies that offer both civilian (BCI) and federal (FBI) electronic fingerprinting for background checks are listed on the following website:

http://www.ohioattorneygeneral.gov/Services/Business/WebCheck/Webcheck-Community-Listing

The student shall be responsible for all costs associated with the criminal records check. Please be sure to identify the college as the agency to receive the results. The results must be sent directly from the Bureau of Criminal Identification and Investigation to the college to be valid. Please have your results sent to:

Emergency Medical Services (EMS) Program Coordinator
Clark State Community College
P. O. Box 570
Springfield, Ohio 45501

The information provided in the criminal records report will only be used to evaluate the student's qualifications for entry into clinical courses. Reports will be kept in secured confidential files separate from the student's academic file with access limited to authorized college personnel. The results will be destroyed two years after the individual is no longer enrolled in the EMS program.

Criminal record reports will undergo administrative review. If a student has been convicted of or pled guilty to a disqualifying offense (or any substantially equivalent offenses in any state), the student may be unable to complete clinical learning experiences and may therefore be disqualified from admission, readmission, or progression in the health care program. Some of the disqualifying offenses are permanent exclusions while others are time limited exclusions. The permanent and time-limited disqualifying offenses are listed in the following table.

In the event that the student's background check includes a disqualifying offense that prevents placing the student at clinical sites, the student will be asked to schedule a meeting with the Emergency Medical Services (EMS) Program Coordinator to discuss the information received. If the background check identifies offenses that the student considers incorrect, these concerns or issues must be addressed, by the student, to the Bureau of Criminal Identification and Investigation for resolution. If the background check correctly identifies disqualifying offenses that prevent clinical placement, the student will be informed of such and advised to withdraw from the clinical course and program. Some clinical facilities may decide not to accept students who have been convicted of minor misdemeanors or felonies not included in the Disqualifying Offenses table. In addition, some clinical facilities may require consideration of expunged convictions in placement decisions.

All students who are admitted to a health care program have a continual obligation to report any criminal conviction to the Health, Human, and Public Services Division Dean within 30 days of its occurrence. Failure to do so will result in immediate dismissal from the program. Some clinical agencies require a criminal background check every year for students enrolled in programs with clinical experiences that span more than one year.

Attached is the list of disqualifying offenses with exclusionary periods that will prevent a student from participating in clinical courses.

Tier I Permanent Exclusion	**Tier II 10 Year Exclusion (from the date the individual is fully discharged from all imprisonment, probation, or parole)**
Aggravated Murder Murder Voluntary Manslaughter Felonious Assault Permitting Child Abuse Failing to provide for a functionally impaired person Patient Abuse or Neglect Patient Endangerment Kidnapping Abduction Human Trafficking Unlawful conduct with respect to documents Rape Sexual Battery Unlawful sexual conduct with a minor Gross sexual imposition Importuning Voyeurism Felonious sexual penetration Disseminating matter harmful to juveniles Pandering Obscenity Pandering Obscenity involving a minor Pandering sexually-oriented matter involving a minor Illegal use of a minor in nudity-oriented material or performance Soliciting or providing support for an act of terrorism Making terroristic threats Terrorism Medicaid fraud **ALSO**, if related to an offense listed above Conspiracy Attempt Complicity **ALSO,** a conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding illegal use of SNAP or WIC program benefits which are Tier II offenses.	**NOTE:** The individual is subject to **a fifteen-year exclusionary period** if the individual was convicted of one of the following offenses and another Tier II, III or IV offense if the multiple disqualifying offense(s) are not the result of, or connected to, the same act. Involuntary manslaughter Reckless Homicide Child Stealing Child Enticement Extortion Compelling Prostitution Promoting Prostitution Enticement or solicitation to patronize a prostitute Procurement of a prostitute for another Aggravated Arson Arson Aggravated robbery Aggravated burglary Illegal use of SNAP or WIC program benefits Workers compensation fraud Identity fraud Aggravated riot Carrying concealed weapons Illegal conveyance or possession of a deadly weapon or dangerous ordnance in a school safety zone. Illegal possession of an object indistinguishable from a firearm in a school safety zone. Illegal conveyance, possession, or control of a deadly weapon or ordnance into a courthouse. Having weapons while under disability Improperly discharging a firearm at or into a habitation or school Discharge of a firearm at or near prohibited premises Improperly furnishing firearms to a minor Engaging in a pattern of corrupt activity Participating in a criminal gang Illegal manufacture of drugs or cultivating marijuana Corrupting another with drugs Trafficking in drugs Illegal assembly or possession of chemicals for the manufacture of drugs Placing harmful or hazardous objects in food or confection **ALSO**, if related to an offense listed above Conspiracy Attempt Complicity

Tier III Seven Year Exclusion (from the date the individual is fully discharged from all imprisonment, probation, or parole)	**Tier IV Five Year Exclusion Period (from the date the individual is fully discharged from all imprisonment, probation, or parole)**
NOTE: The individual is subject to a **ten-year exclusionary period** if the individual was convicted of one of the following offenses and another Tier III or IV offense if the multiple disqualifying offense(s) are not the result of, or connected to, the same act. Cruelty to animals Prohibition concerning companion animals Aggravated Assault Aggravated menacing Menacing by stalking Coercion Disrupting public services Robbery Burglary Insurance Fraud Inciting to violence Riot Inducing Panic Endangering Children Domestic Violence Intimidation Perjury Falsification Escape Aiding escape or resistance to lawful authority Illegal conveyance of weapons, drugs, or other prohibited items onto the grounds of a detention facility/institution Funding drug trafficking Illegal administration or distribution of anabolic steroids Tampering with drugs Ethnic Intimidation **ALSO**, if related to an offense listed above Conspiracy Attempt Complicity	**NOTE:** The individual is subject to a **seven-year exclusionary period** if the individual was convicted of multiple Tier IV offenses if the multiple offenses are not the result of, or connect to, the same act. Assault Menacing Public Indecency Soliciting, engaging in solicitation after an HIV + test Prostitution Deception to obtain harmful matter to juveniles Breaking and Entering Theft Unauthorized use of a motor vehicle Unauthorized use of a computer, cable or telecommunication property Telecommunications fraud Passing Bad Checks Misuse of credit cards Forgery, forging identification cards Criminal simulation Defrauding a rental agency or hostelry Tempering with records Securing Writings by deception Personating an officer Unlawful display of law enforcement emblem Defrauding creditors Receiving stolen property Unlawful abortion Unlawful abortion upon a minor Unlawful distribution of an abortion inducing drug Interference with custody Contributing to the unruliness or delinquency of a child Tampering with evidence Compounding a crime Disclosure of confidential information Obstructing Justice Assaulting or harassing a police dog, horse or service animal Impersonation of a peace officer Illegal administration, dispensing, manufacture, possession, selling, or using any dangerous veterinary drug Drug Possession, unless a minor drug possession offense Permitting drug abuse Deception to obtain a dangerous drug Illegal processing of a drug document Illegal dispensing of drug samples Unlawful purchase, underage purchase, improper purchase, using false information to purchase a pseudoephedrine product Unlawfully selling, improper sale of a pseudoephedrine product **ALSO**, if related to an offense listed above Conspiracy Attempt Complicity

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