

NORTHAMPTON

COMMUNITY COLLEGE

RN and LPN REACTIVATION REQUIREMENTS

PROGRAM REQUIREMENTS STUDENT CHECKLIST

Students who fail to submit documents by the required dates will not qualify to participate in all aspects of the class. All associated student requirement costs are the responsibility of the student.

| | SECTION | REQUIREMENT | INSTRUCTIONS AND IMPORTANT NOTES |
|--------------------------|-----------|---|--|
| <input type="checkbox"/> | Section A | Verification of Residency | <ul style="list-style-type: none"> Fill out and upload to MyRecordTracker |
| <input type="checkbox"/> | Section B | Photo Identification | <ul style="list-style-type: none"> Upload front and back of State-issued Driver's License or State-issued Photo ID |
| <input type="checkbox"/> | Section C | Student Information Form | <ul style="list-style-type: none"> Fill out and upload to MyRecordTracker |
| <input type="checkbox"/> | Section D | Pennsylvania Criminal Background Clearance | <ul style="list-style-type: none"> PATCH - see detailed instructions to complete online Do immediately! |
| <input type="checkbox"/> | Section E | FBI Criminal Background Clearance | <ul style="list-style-type: none"> See detailed instructions (including fingerprinting) Do immediately! It may take up to 2 weeks to come back after fingerprinting but may take as long as 1 month. |
| <input type="checkbox"/> | Section F | Submit a Request for a Child Abuse Clearance | <ul style="list-style-type: none"> Follow directions for submitting and upload results to MyRecordTracker |
| <input type="checkbox"/> | Section G | FBI Background Clearance Instructions (Aging) | <ul style="list-style-type: none"> If you have not lived in Pennsylvania for past two (2) consecutive years, you are required to do this. Upload to MyRecordTracker |
| <input type="checkbox"/> | Section H | Child Abuse Mandated Report Training | <ul style="list-style-type: none"> Follow directions for submitting and upload results to MyRecordTracker |
| <input type="checkbox"/> | Section I | Background Check Review Process | <ul style="list-style-type: none"> Background check review process information |
| <input type="checkbox"/> | Section J | Positive Background Clearance Information | <ul style="list-style-type: none"> If you have an issue with one of your clearances - this is required if you would like to be considered for program. Please follow directions. |
| <input type="checkbox"/> | Section K | Student Release of Information for Allied Health clinical sites | <ul style="list-style-type: none"> Fill out and upload to MyRecordTracker |
| <input type="checkbox"/> | Section L | Student Health Requirements | <ul style="list-style-type: none"> Listing of Health Requirements Student Health Form TB Screening Requirements |
| <input type="checkbox"/> | Section M | OSHA InfoSheet | <ul style="list-style-type: none"> Fill out, take along when you go for your physical. Have physician fill out and sign Fit Test Medical Clearance |
| <input type="checkbox"/> | Section N | Urine Drug Screening | <ul style="list-style-type: none"> Please read directions |
| <input type="checkbox"/> | Section O | Medical Marijuana Policy | <ul style="list-style-type: none"> Read, sign and upload to MyRecordTracker |
| <input type="checkbox"/> | Section P | Student Emergency Contact Information | <ul style="list-style-type: none"> Fill out and upload to MyRecordTracker |
| <input type="checkbox"/> | Section Q | Student Agreement | <ul style="list-style-type: none"> Read, sign and upload to MyRecordTracker |
| <input type="checkbox"/> | Section R | Felony Disclosure Form | <ul style="list-style-type: none"> Read, sign and upload to MyRecordTracker |
| <input type="checkbox"/> | Section S | Basic Life Support | <ul style="list-style-type: none"> Please provide a copy of your current BLS. If you do not have current, courses are available through N.C.C. |

| | | | |
|--------------------------|-----------|-------------------------------|---|
| <input type="checkbox"/> | Section T | Miscellaneous Forms | <ul style="list-style-type: none"> • Covid 19 Policy • Privacy and Confidentiality • Permission for Release of Student Information • Photography / Video Release • Confidentiality Agreement |
| <input type="checkbox"/> | Section U | Nursing License | <ul style="list-style-type: none"> • Please upload your Nursing License to MyRecord Tracker and verification from your State's website of your current status. |
| <input type="checkbox"/> | Section V | MyRecordTracker Student Guide | <ul style="list-style-type: none"> • Guide for uploading to MyRecordTracker |

4/26/23

VERIFICATION OF RESIDENCY **Section A**

NORTHAMPTON
COMMUNITY COLLEGE

Verification of Residency for Acceptance into an NCC Health Science Program

Date: _____ Class Start Date: _____

Student Name: _____
Last First Middle

Current Address: _____
Street Address

City State Zip Code

- I lived at the above Pennsylvania address for two (2) consecutive years or more.
- I lived in Pennsylvania for two (2) consecutive years or more at my current address and previous addresses listed below:

1. Prior Address: _____
Street Address

City State Zip Code

I lived at this address from _____ until _____
MM/DD/YYYY MM/DD/YYYY

2. Prior Address: _____
Street Address

City State Zip Code

I lived at this address from _____ until _____
MM/DD/YYYY MM/DD/YYYY

- I have NOT lived in Pennsylvania for the past two (2) or more consecutive years and must submit a PA Department of Aging FBI Background Clearance through IdentoGO (Service Code **1KG 8RJ**).

By submitting this form, I certify all the information I have provided is complete, accurate, true, and correct. I make this declaration subject to the penalties of 18 Pa. C.S. §4904 relating to unsworn falsification to authorities.

Signature: _____ Date: _____

For NCC Staff Use Only

- I am the Authorized NCC Representative who received this completed form and verified the applicant's current residency by comparison with an official State-issued photo identification.
- I have verified the applicant's residency for the past two (2) consecutive years or more.

PA Department of Aging FBI clearance needed: Yes N/A

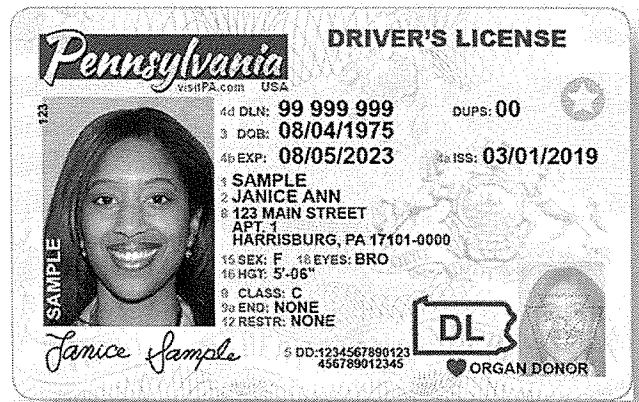
Authorized NCC Representative: _____

Title: _____ Date: _____

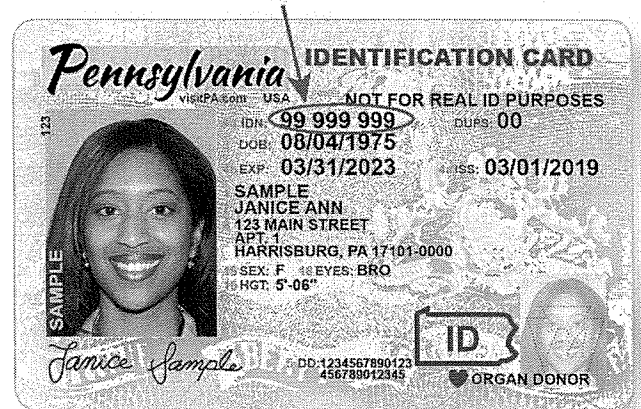
PHOTO IDENTIFICATION REQUIREMENTS

The address listed on your State-issued Driver's License or Photo ID must match the current address listed on your Verification of Residency Form (Section A). If it does not, please obtain a Change of Address card. This information is needed so you can determine whether or not you need to obtain a PA Department of Aging FBI Background Clearance which is required if you have not lived in Pennsylvania for the past two (2) consecutive years. Thank you!

State-issued Driver's License



State-issued Identification Card



PennDOT Change of Address Website

<https://www.dmv.pa.gov/Driver-Services/Name-Address-Changes/Pages/Changing-Your-Address.aspx>

**NORTHAMPTON
COMMUNITY COLLEGE
HEALTHCARE EDUCATION
Student Information Sheet**

PLEASE PRINT

Name: _____

Preferred or Chosen Name: _____

Address: _____

City/State/Zip: _____

County: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Social Security No: _____

Please check here if we may send you periodic email updates about our classes and programs.

Date of Birth: _____ Marital Status: S M W D SEP

Gender: Male Female Other: _____

Preferred Pronoun: He/Him She/Her They/Them

NURSING BACKGROUND

1. RN LPN Original State/Country of Licensure: _____

2. What is the status of your **Pennsylvania Nursing License**? Active Inactive No License

3. PA License #: _____ Other State License #: _____

WORK EXPERIENCE

1. Are you currently employed in healthcare? Yes No

2. If yes, name and location of employer: _____

3. What is your job title? _____

4. If no, length of time out of practice _____

5. Last nursing position _____

MINORITY INFORMATION

The following information is requested to monitor the compliance posture of the institution and will be used only to collect and maintain data on the race, sex, and ethnic identity of all students. This information may be requested on national and state statistical reports. *Please check all that apply to you. (OPTIONAL)*

American Indian Asian Black/African American Native Hawaiian or Other Pacific Islander

Pacific Islander Caucasian Hispanic/Latino Other _____

Language: _____
Primary Secondary

Have you taken ESL courses? Yes No

Submitting a Request for PA Criminal History Record Check (PATCH)

A Pennsylvania Criminal Background Check is required of all NCC Health Career students. To obtain your record follow the steps below:

1. Go to <https://epatch.pa.gov/home>.
2. Select the **Submit a New Record Check** option. **Do NOT use the gold box titled "New Record Check (Volunteers only)" option.**
3. Read the **Terms and Conditions** surrounding use of the system in order to proceed with record check request submission. Click on **Accept**.
4. Complete the **Personal Information** form.
 - a. Select **Other** from the drop-down list as **Reason for Request**.
 - b. Name, address and telephone number are required fields.
5. Click **Next** and the screen will display the personal details entered in the last step. Review details and click the **Proceed** button.
6. Complete the **Record Check Request Form**.
 - a. Name, Social Security Number, Date of Birth, Sex, & Race.
 - b. List all aliases and/or Maiden Names.
 - c. Click **Enter this Request**
7. Confirm the **Record Check Request Review** and click on **Submit**. The charge is **\$22.00** per request.
8. Complete the **Credit Card Information** form. PATCH accepts Visa, Discover, Master Card, and American Express.

Required information:

 - a. Name and address
 - b. Credit Card Type and Credit Card Number
 - c. Card Verification Method (CVM) number
 - d. Expiration Date
9. Click **Next** once the form has been completed.
10. PATCH will display the credit card information entered in the last step. Review the details. Click **Back** if any of the information needs to be changed. Otherwise, click **Submit**.
11. At this point, PATCH will charge the credit card entered for the amount shown. Once the submit button is clicked, this transaction will be processed. This cannot be undone.
12. PATCH will display a summary listing of the Record Check Results.
 - a. Details on the record check result can be reviewed by clicking on your name.
 - b. Click on the Invoice Number in the Record.
 - c. Check Details page to access a printable invoice.
 - d. Click on blue link titled **Certification Form** in the Record. This will bring up the record with the State seal.
Please print multiple copies, as you may need this for employment or licensure purposes.
13. PATCH report will either show:
 - a. **No Record** status if there are no records found for the request, *or*
 - b. **Request Under Review**. A "Request Under Review" response **does not** necessarily indicate a criminal record. If this occurs, log on to the website daily to check status. You will not be notified when the results are updated. Once the results are in, follow Step 12d. above to access and print the report, including the RAP sheet if the response indicates a criminal record.
14. Upload your PATCH Clearance results to your student account at <https://www.myrecordtracker.com>.
15. **IF YOUR CLEARANCE COMES BACK WITH A RECORD**, you must submit the **original**, including the accompanying Rap Sheet, together with a letter of explanation of the charges to the Program Director, since there are additional steps that must be taken for clinical approval. Be sure to keep a copy for your records, which may be needed for future employment or volunteer opportunities.

Submitting a Request for an FBI Criminal Background Clearance

The NCC Health Career Programs require Federal Bureau of Investigation (FBI) criminal background checks on all students. The fingerprint-based background check is a multiple-step process. Please complete the following steps of the process promptly to assure you meet the **firm deadline** for submitting results. **Please be advised that failure to comply with this requirement by the established deadline will result in cancellation of your acceptance and/or removal from the Health Career Program.**

1. **Registration:** The applicant must register prior to going to the fingerprint site. Walk in service is allowed but all applicants are required to complete pre-enrollment in the new Universal Enrollment system. Pre-enrollment can be completed online or over the phone. The registration website is available online 24 hours/day, seven days per week at <https://uenroll.identogo.com>. Telephonic registration is available at 1-844-321-2101 Monday through Friday, 8:00 a.m. to 6:00 p.m. EST. During the pre-enrollment process, all demographic data for the applicant is collected (name, address, etc.) along with notices about identification requirements and other important information.

When registering online, an applicant must use the appropriate agency specific Service Code to ensure they are processed for the correct agency and/or applicant type. Using the correct service code ensures the background check is submitted for the correct purpose.

Enter Service Code: 1KG 756

2. **Employer:**

Northampton Community College
For Main or Pocono Campuses, enter: 3835 Green Pond Road, Bethlehem, PA 18020
For Fowler Campus, enter: 511 E. Third Street, Bethlehem, PA 18015
3. Applicants who register under Identogo for fingerprints can receive their results electronically. This opportunity applies to results with no record. During the registration process you will be asked for an email address, and you will be asked to create a security question and a security answer. It is very important that once you create your security question and answer that you retain this information. Three (3) unsuccessful logins will prevent you from retrieving your results. This information cannot be reset.
4. **Payment:** The applicant will pay a fee of **\$25.25** for the fingerprint service and to secure an official copy of the Criminal History Record. Major Credit Cards as well as Money orders or cashier's checks payable to **MorphoTrust** will be accepted on site for those applicants who are required to pay individually. **No cash transactions or personal checks are allowed.**
5. **Fingerprint Locations:** After registration, the applicant proceeds to the fingerprint site of their choice for fingerprinting. The location of the fingerprint sites and days and hours of operation for each site are posted on IDEMIA's website at <https://uenroll.identogo.com>. The location of fingerprint sites may change over time; applicants are encouraged to confirm the site location nearest to their location.

| LOCATION | DAYS | HOURS |
|---|-----------------------------|--|
| HELLERTOWN | | |
| IdentoGO 1866 Leithsville Road Creekside Marketplace Hellertown, PA 18055-2505 | Monday – Friday Saturday | 09:00 AM - 05:00 PM 09:00 AM - 01:00 PM |
| ALLENTOWN | | |
| IdentoGO 1382 Hanover Avenue Allentown Commons Plaza Allentown, PA 18109-2019 | Monday – Friday | 09:00 AM - 12:00 PM <i>and</i> 12:30 PM - 04:30 PM |

| LOCATION | DAYS | HOURS |
|---|-----------------------------|--|
| EAST STROUDSBURG | | |
| IdentoGO 5224 Milford Road Suite 155 East Stroudsburg, PA 18302-9671 | Monday – Friday Saturday | 09:30 AM - 06:30 PM 09:30 AM - 02:30 PM |

6. **Fingerprinting:** At the fingerprint site, the Enrollment Agent (EA) manages the fingerprint collection process. The fingerprint transaction begins when the EA reviews the applicant's qualified State or Federal photo ID before processing the applicant's transaction. A list of approved ID types may be found on the IDEMIA website at <https://uenroll.identogo.com>. **Applicants will not be processed if they cannot produce an acceptable photo ID.** After the identity of the applicant has been established, all ten fingers are scanned to complete the process. The entire fingerprint capture process should take no more than three to five minutes.

| ACCEPTABLE DOCUMENTS |
|--|
| <ul style="list-style-type: none"> ➤ Canadian Commercial Driver's License (CDL) ➤ Commercial Driver's License issued by a State or outlying possession of the U.S. ➤ Department of Defense Common Access Card ➤ Driver's License PERMIT issued by a State or outlying possession of the U.S. ➤ Driver's License issued by a State or outlying possession of the U.S. ➤ Employment Authorization Card/Document (I-766) with Photo ➤ Enhanced Tribal Card (ETC) ➤ Foreign Driver's License (Mexico and Canada Only) ➤ Foreign Passport ➤ Merchant Mariner Document (MMD) ➤ Military Dependent's Card ➤ Military ID Card ➤ Passport Book or Card ➤ Permanent Resident Card / Green Card (I-551) ➤ Photo ID Waiver for Minors ➤ State ID Card (or outlying possession of the U.S.) with a seal or logo from State or State Agency ➤ Uniformed Services Identification Card (Form DD-1172-2) ➤ Visa |

7. Shortly after your fingerprints have been taken and a result can be provided, you will receive an email. You will be advised to click on the link within the email and enter your security question and answer. If you lock yourself out of your security question and answer, your result will be mailed by US Mail. Current Mailing timelines take 7 to 10 business days to reach the intended destination.

When you do access your result, it is important that you be able to download it, save it and print it for future needs. There will be no second access to this electronic result.

If any result has a record associated with it, those results will not be electronically available and can only be mailed by US Mail. Current Mailing timelines take 7 to 10 business days to reach the intended destination.

8. Upload results of your FBI Clearance **PRIOR TO THE DUE DATE** given to your student account at <https://www.myrecordtracker.com>.
9. Once uploaded, check with your Program Director to determine if you are required to submit the **original** document to the College as part of fulfilling your clinical requirement.
10. **IF YOUR CLEARANCE COMES BACK WITH A RECORD**, you are **REQUIRED** to submit the **original** to the Program Director, including the **accompanying Rap Sheet**, together with a **letter of explanation** of the charges. Please contact the Program Director immediately if you feel there is something that will come up on your background clearance since there are additional steps that must be taken for clinical approval. Be sure to keep a copy for your records, which may be needed for future employment or volunteer opportunities.

Submitting a Request for Child Abuse Clearance

A Child Abuse History Clearance is required of all NCC Health Career students. **Applications are submitted online, but it may still take several weeks to receive the results.**

Please note: Failure to follow the instructions below may cause a considerable delay in the processing of your application and could affect your ability to meet the deadline for submitting results. Please be advised that failure to comply with this requirement by the established deadline will result in cancellation of your acceptance and/or removal from the Health Career Program.

1. Please go to the **PA Child Welfare Information Solution Portal** at <https://www.compass.state.pa.us/CWIS>.
2. Select **"Create Individual Account"** and follow the instructions to create a Keystone ID account. You will be asked to provide some personal information and answer security questions.
 - a. Creation of your Keystone ID will prompt their system to send you two e-mails. One will contain confirmation of your recently created Keystone ID and the other will provide you with a temporary password.
 - b. Go back to the Child Welfare Portal website at <https://www.compass.state.pa.us/CWIS> and choose the **"Individual Login."** Choose **"Access my Clearance"**. Read **"Learn More"** and scroll down to **"continue"** to login.
 - c. Login by using your Keystone ID using the temporary password copied and pasted from the email sent to you.
 - d. Once logged in, the system will require you to immediately change the password. Set permanent password and click **"Submit"**. The website will then tell you to click on **"Close Window"** button.
 - e. Login again to your application with your Keystone ID and newly created personal password.
3. **My Child Welfare Account Terms & Conditions**
 - a. Choose to accept the Terms & Conditions and click **"Next."**
 - b. On the "My PA Child Abuse History Clearances" screen choose **"Create Clearance Application."**
4. **Getting Started**
 - A. Scroll to bottom and select **"Begin"**. Complete the Application in full.
 - a. Complete the following sections: Application Purpose, Application Info, Current Address, Previous Address, Household Members, & Application Summary. (The form asks for all previous names, addresses, and household members since 1975). This information must be provided to the best of your knowledge and belief.
 - b. The last part consists of the following sections: eSignature and Application Payment.
5. **Application Purpose**
 - a. Select **"School Employee Not Governed by Public School Code."**
6. **Payment**
 - A. Finish completing application process. Payment of \$13.00 is required at time of request. Debit or credit cards will be accepted. If the system gives you the option to print the results out immediately as well as have one sent to you in the mail, please choose both options.
7. Upload results of your Child Abuse Clearance to your student account at <https://www.myrecordtracker.com>. Keep a copy for your records.
8. **IF YOUR CLEARANCE COMES BACK WITH A RECORD**, you are **REQUIRED** to submit the **original** to the Program Director, including the accompanying Rap Sheet, together with a letter of explanation of the charges. Please contact the Program Director immediately if you feel there is something that will come up on your background clearance since there are additional steps that must be taken for clinical approval. Be sure to keep a copy for your records, which may be needed for future employment or volunteer opportunities.

Submitting a Request for an FBI PA Department of Aging Clearance

If you have not lived in Pennsylvania for the past two (2) consecutive years, you are required to obtain an FBI through the Pennsylvania Department of Aging. Please follow the instructions listed below:

11. **Registration:** The applicant must register prior to going to the fingerprint site. Walk in service is allowed but all applicants are required to complete pre-enrollment in the new Universal Enrollment system. Pre-enrollment can be completed online or over the phone. The registration website is available online 24 hours/day, seven days per week at <https://uenroll.identogo.com>. Telephonic registration is available at 1-844-321-2101 Monday through Friday, 8:00 a.m. to 6:00 p.m. EST. During the pre-enrollment process, all demographic data for the applicant is collected (name, address, etc.) along with notices about identification requirements and other important information.

When registering online, an applicant must use the appropriate agency specific Service Code to ensure they are processed for the correct agency and/or applicant type. Using the correct service code ensures the background check is submitted for the correct purpose.

Enter Service Code: 1KG 8RJ

Employer: Northampton Community College

For Main or Pocono Campuses, enter: 3835 Green Pond Road, Bethlehem, PA 18020

For Fowler Campus, enter: 511 E. Third Street, Bethlehem, PA 18015

13. Applicants who register under Identogo for fingerprints can receive their results electronically. This opportunity applies to results with no record. During the registration process you will be asked for an email address, and you will be asked to create a security question and a security answer. It is very important that once you create your security question and answer that you retain this information. Three (3) unsuccessful logins will prevent you from retrieving your results. This information cannot be reset.

14. **Payment:** The applicant will pay a fee of **\$25.25** for the fingerprint service and to secure an official copy of the Criminal History Record. Major Credit Cards as well as Money orders or cashier's checks payable to **MorphoTrust** will be accepted on site for those applicants who are required to pay individually. **No cash transactions or personal checks are allowed.**

15. **Fingerprint Locations:** After registration, the applicant proceeds to the fingerprint site of their choice for fingerprinting. The location of the fingerprint sites and days and hours of operation for each site are posted on IDEMIA's website at <https://uenroll.identogo.com>. The location of fingerprint sites may change over time; applicants are encouraged to confirm the site location nearest to their location.

| LOCATION | DAYS | HOURS |
|---|-----------------------------|--|
| HELLERTOWN | | |
| 1866 Leithsville Road Creekside Marketplace Hellertown, PA 18055-2505 | Monday – Friday Saturday | 09:00 AM - 05:00 PM 09:00 AM - 01:00 PM |
| ALLENTOWN | | |
| 1382 Hanover Avenue Allentown Commons Plaza Allentown, PA 18109-2019 | Monday – Friday | 09:00 AM - 12:00 PM <i>and</i> 12:30 PM - 04:30 PM |
| LOCATION | DAYS | HOURS |
| EAST STROUDSBURG | | |
| 5224 Milford Road Suite 155 East Stroudsburg, PA 18302-9671 | Monday – Friday Saturday | 09:30 AM - 06:30 PM 09:30 AM - 02:30 PM |

16. **Fingerprinting:** At the fingerprint site, the Enrollment Agent (EA) manages the fingerprint collection process. The fingerprint transaction begins when the EA reviews the applicant's qualified State or Federal photo ID before processing the applicant's transaction. A list of approved ID types may be found on the IDEMIA website at <https://uenroll.identogo.com>. **Applicants will not be processed if they cannot produce an acceptable photo ID.** After the identity of the applicant has been established, all ten fingers are scanned to complete the process. The entire fingerprint capture process should take no more than three to five minutes.

ACCEPTABLE DOCUMENTS

- Canadian Commercial Driver's License (CDL)
- Commercial Driver's License issued by a State or outlying possession of the U.S.
- Department of Defense Common Access Card
- Driver's License PERMIT issued by a State or outlying possession of the U.S.
- Driver's License issued by a State or outlying possession of the U.S.
- Employment Authorization Card/Document (I-766) with Photo
- Enhanced Tribal Card (ETC)
- Foreign Driver's License (Mexico and Canada Only)
- Foreign Passport
- Merchant Mariner Document (MMD)
- Military Dependent's Card
- Military ID Card
- Passport Book or Card
- Permanent Resident Card / Green Card (I-551)
- Photo ID Waiver for Minors
- State ID Card (or outlying possession of the U.S.) with a seal or logo from State or State Agency
- Uniformed Services Identification Card (Form DD-1172-2)
- Visa

17. **ALL OUT-OF-STATE RESIDENTS, PLEASE NOTE:** if you enter your zip code and find there is no fingerprinting location in your own State, you can create an appointment and select the option to have local law enforcement do a physical fingerprinting, which can then be sent by mail to Identogo. This takes a little extra time (6-8 weeks), but it should not cause a significant delay in your application. **(You will need 2 cards: one for Dept. of Human Services and one for PA Dept. of Aging.)**

18. Shortly after your fingerprints have been taken and a result can be provided, you will receive an email. You will be advised to click on the link within the email and enter your security question and answer. If you lock yourself out of your security question and answer, your result will be mailed by US Mail. Current Mailing timelines take 7 to 10 business days to reach the intended destination.

When you do access your result, it is important that you be able to download it, save it and print it for future needs. There will be no second access to this electronic result.

If any result has a record associated with it, those results will not be electronically available and can only be mailed by US Mail. Current Mailing timelines take 7 to 10 business days to reach the intended destination.

19. Upload results of your FBI Aging Clearance **PRIOR TO THE DUE DATE** given to your student account at <https://www.myrecordtracker.com>.

20. Once uploaded, check with your Program Director to determine if you are required to submit the **original** document to the College as part of fulfilling your clinical requirement.

21. **IF YOUR CLEARANCE COMES BACK WITH A RECORD**, you are **REQUIRED** to submit the **original** to the Program Director, including the **accompanying Rap Sheet**, together with a **letter of explanation** of the charges. Please contact the Program Director immediately if you feel there is something that will come up on your background clearance since there are additional steps that must be taken for clinical approval. Be sure to keep a copy for your records, which may be needed for future employment or volunteer opportunities.

Child Abuse Mandated Report Training

The online Child Abuse Mandated Reporter Training must be completed for the Allied Program you are completing.

7. The course is offered free of charge through the University of Pittsburgh.

8. Please access the course by copying and pasting the link below:

[https://www.reportabusepa.pitt.edu/webapps/portal/execute/tabs/tabAction?tab_group_id= 2 1.](https://www.reportabusepa.pitt.edu/webapps/portal/execute/tabs/tabAction?tab_group_id=21)

9. Click on the "Registration" link at the top of the page and create an account. Be sure to save your login information for future use.

10. The course may take up to three hours to complete but does not have to be done all at once. You may save your progress and return to it at another time using your login information.

11. At the end of the course, you will be prompted to print your Certificate of Completion. Be sure to print out multiple copies for your records since you may need it for licensure.

NORTHAMPTON

COMMUNITY COLLEGE

****IMPORTANT BACKGROUND CHECK REVIEW PROCESS INFORMATION****

A Pennsylvania State Police Criminal History Report, FBI Criminal History Record Report, and Pennsylvania Child Abuse History Clearance must be completed by all Allied Health students by the deadline noted within this Acceptance Checklist in order to comply with clinical facility requirements. Acceptance is considered conditional until the criminal background check requirement is met. The timeline is established to allow adequate time for the Allied Health Review Committee to review the report and make a recommendation to the Program Director regarding full acceptance into the program. Acceptance will be rescinded if the documents are not received by the deadline.

Students with three (3) reports reflecting “no record” (no convictions) can consider themselves fully accepted.

If there is a positive record, entry into clinical education will be dependent on the decision of the Allied Health Review Committee after the **background clearances, including the RAP sheet**, together with a written, detailed explanation are uploaded to myRecordTracker® (See Section E). Upon receipt of the statement and clearances, the Allied Health Review Committee will review the reports and make a recommendation to the Program Director regarding the student’s acceptance into the program. Students will be notified of their status within three (3) days of the committee’s review. The student may appeal the decision in writing to the Vice President for Academic Affairs (VPAA) within five (5) working days of notification receipt. The decision of the VPAA is final. The records related to the criminal background process for students will be secured in the Dean’s office.

Clinical agencies have the right to deny access to any student with a criminal record based on that site’s own criteria. In the event that a student is denied clinical placement based on their criminal record, their acceptance may be rescinded.

The following page contains a list of Prohibitive Offenses which may make it difficult to obtain an internship/externship or employment position within a healthcare facility.

Prohibitive Offenses Contained in 63 P.S. § 675

In no case shall an applicant for enrollment in a State-approved nurse aide training program be admitted into a program if the applicant's criminal history record information indicates a conviction of any of the following offenses:

1. An offense designated as a felony under the act of April 14, 1972 (P.L. 233, No. 64), known as "The Controlled Substance, Drug, Device and Cosmetic Act." (See 35 P.S. § 780-101 et seq.). These offenses may be designated as "CS" on a criminal rap sheet.
2. An offense under one or more of the following provisions of Title 18 of the Pennsylvania Consolidated Statutes below.
3. A Federal or out-of-State offense similar in nature to those crimes listed under paragraphs (1) and (2).

| Offense Code | Prohibitive Offense Description | Type/Grading of Conviction |
|--------------|--|----------------------------|
| CC2501 | Criminal Homicide | Any |
| CC2502 | Murder | Any |
| CC2503 | Voluntary Manslaughter | Any |
| CC2504 | Involuntary Manslaughter | Any |
| CC2505 | Causing or Aiding Suicide | Any |
| CC2506 | Drug Delivery Resulting in Death | Any |
| CC2507 | Criminal Homicide of Law Enforcement Officer | Any |
| CC2702 | Aggravated Assault | Any |
| CC2901 | Kidnapping | Any |
| CC2902 | Unlawful Restraint | Any |
| CC3121 | Rape | Any |
| CC3122.1 | Statutory Sexual Assault | Any |
| CC3123 | Involuntary Deviate Sexual Intercourse | Any |
| CC3124.1 | Sexual Assault | Any |
| CC3125 | Aggravated Indecent Assault | Any |
| CC3126 | Indecent Assault | Any |
| CC3127 | Indecent Exposure | Any |
| CC3301 | Arson and Related Offenses | Any |
| CC3502 | Burglary | Any |
| CC3701 | Robbery | Any |
| CC3901 | Theft | 1 Felony or 2 Misdemeanors |
| CC3921 | Theft by Unlawful Taking | 1 Felony or 2 Misdemeanors |
| CC3922 | Theft by Deception | 1 Felony or 2 Misdemeanors |
| CC3923 | Theft by Extortion | 1 Felony or 2 Misdemeanors |
| CC3924 | Theft by Property Lost | 1 Felony or 2 Misdemeanors |
| CC3925 | Receiving Stolen Property | 1 Felony or 2 Misdemeanors |
| CC3926 | Theft of Services | 1 Felony or 2 Misdemeanors |
| CC3927 | Theft by Failure to Deposit | 1 Felony or 2 Misdemeanors |
| CC3928 | Unauthorized Use of a Motor Vehicle | 1 Felony or 2 Misdemeanors |
| CC3929 | Retail Theft | 1 Felony or 2 Misdemeanors |
| CC3929.1 | Library Theft | 1 Felony or 2 Misdemeanors |
| CC3929.2 | Unlawful Possession of Retail or Library Theft Instruments | 2 Misdemeanors |
| CC3929.3 | Organized Retail Theft | 1 Felony or 2 Misdemeanors |
| CC3930 | Theft of Trade Secrets | 1 Felony or 2 Misdemeanors |
| CC3931 | Theft of Unpublished Dramas or Musicals | 1 Felony or 2 Misdemeanors |
| CC3932 | Theft of Leased Properties | 1 Felony or 2 Misdemeanors |
| CC3934 | Theft from a Motor Vehicle | 1 Felony or 2 Misdemeanors |
| CC4101 | Forgery | Any |
| CC4114 | Securing Execution of Document by Deception | Any |
| CC4302 | Incest | Any |
| CC4303 | Concealing Death of a Child | Any |
| CC4304 | Endangering Welfare of a Child | Any |
| CC4305 | Dealing in Infant Children | Any |
| CC4952 | Intimidation of Witnesses or Victims | Any |
| CC4953 | Retaliation Against Witness or Victim | Any |
| CC5902B | Promoting Prostitution | Felony |
| CC5903C or D | Obscene and Other Sexual Materials and Performances | Any |
| CC6301 | Corruption of Minors | Any |
| CC6312 | Sexual Abuse of Children | Any |

Any two Misdemeanor convictions for offenses CC3901 thru CC3934 in any combination is prohibited.

If you have a positive background check, a letter with the information described below must be sent to the program manager, along with your background check results, providing further information on the convictions and non-convictions that appeared on your record. It is important for us to gain as much information as possible about these charges to fairly evaluate your acceptance into the program. To that end, we request that you submit, in writing to the program director, the following information:

1. Date of conviction
2. Exact location
3. Offense(s)
4. How did you plead?
5. What was the outcome/sentencing?
6. Are you still on probation?
7. Provide details surrounding the offense(s) with your version of what happened.

In addition to your written statement, please provide all documentation you may possess that relates to the above record(s). Inability to comply with this request may result in dismissal from the program.

Should you have any questions, please contact Jaye Brennan, Credentialing Coordinator at jpbrennan@northampton.edu or 610-332-6288.

NORTHAMPTON

COMMUNITY COLLEGE

Student Release of Information Form For Allied Health Clinical Sites Only

The Family Educational Rights and Privacy Act of 1974 (FERPA) protects the student's educational record from disclosure to unauthorized individuals. As an admitted and enrolled student in the NCC Allied Health program, additional documentation is required to be submitted, including criminal background checks and drug screening results. While these items are not part of the student educational record, they are maintained as confidential by the program/division. Northampton Community College is required to share positive results of criminal background checks and drug screening with any affiliated institution used for clinical education in the Allied Health programs.

I understand that information regarding these results will be released to the requestor according to the guidelines outlined in the affiliation agreement between the college and the clinical affiliate.

I understand that the clinical affiliate requires that positive results of my background check(s) be shared with the following individuals: the VP Human Resources, Labor/Employment Counsel, VP Patient Care Services, and/or the manager(s) of the unit where the student is assigned for clinical.

In connection with my admission and enrollment in an NCC Allied Health Program and my participation in the Program's clinical training opportunities, I hereby authorize the College and its agents to release any and all information relevant to my criminal record and/or drug screen results to any authorized clinical site representative it deems appropriate in order to determine my suitability to be enrolled in the Allied Health Program and/or to be assigned to a clinical site selected by the College. A photocopy of this release will be sufficient to authorize the release of the information.

Student Information:

(Please print legibly)

_____ Student ID

_____ Student's Name (Last)

(First)

(Middle)

(Previous)

_____ Address (Street)

(City)

(State)

(Zip)

_____ Primary Phone Number

_____ Secondary Phone Number

_____ Signature of Student Authorizing Release

_____ Date

Student Health Requirements

Enclosed in your admission packet you will find a separate two-part form that must be completed and sent to the program manager. All health-related information must be submitted by the due date given in order to continue in the program. **Failure to submit all of the required information by the due date will result in dismissal from the program.**

The Health and Wellness Center at Northampton Community College is operated by St. Luke's University Health Network, Bethlehem, PA. Physical examinations and some of the required immunizations may be obtained at the Health and Wellness Center. Please call 610-861-5365 for more information or to schedule an appointment.

You may also contact St. Luke's Urgent Care Center, 153 Brodhead Road, Bethlehem, PA, 610-954-3220, to make an appointment for health services if you do not have your own family physician.

Health insurance is **required** for all Allied Health Programs and must be maintained throughout the duration of the Program. It is the student's responsibility to upload a copy of the front and back of the new insurance card immediately.

The checklist below provides an overview of what must be completed on the Health Form. Please be sure to check form BEFORE leaving Medical Provider's Office to ensure all items are completed.

| PAGE 1 – Student Information (to be completed by student) | | |
|---|--|--|
| <input type="checkbox"/> | Personal Information | <ul style="list-style-type: none"> Student to complete <u>and sign</u> first page of health form |
| <input type="checkbox"/> | Health Insurance | <ul style="list-style-type: none"> Students must have personal health insurance Complete health insurance section on first page |
| PAGE 2 – Physical (to be completed by physician) | | |
| <input type="checkbox"/> | Physical Performed by Medical Provider | <ul style="list-style-type: none"> Bring health form and OSHA form to scheduled appointment Medical provider MUST clear student for N95 fit testing Be sure provider <u>initials</u> all boxes on Page 2 of Health Form and also signs form |
| PAGE 3 – Immunizations and Titers | | |
| <input type="checkbox"/> | Varicella | <ul style="list-style-type: none"> Must show proof of two Varicella vaccinations – <i>OR</i> – Titer to prove immunity Proof of disease is NOT acceptable |
| <input type="checkbox"/> | MMR | <ul style="list-style-type: none"> Must provide proof of two MMR vaccinations – <i>OR</i> – Titer to prove immunity |
| <input type="checkbox"/> | Hepatitis B | <ul style="list-style-type: none"> Must provide proof of three Hepatitis B vaccinations |
| <input type="checkbox"/> | Hepatitis B Surface Antibody – QUANTITATIVE Titer ***REQUIRED*** | <ul style="list-style-type: none"> Must obtain Hep B Surface Antibody in addition to Hep B vaccination dates to show immunity or lack of immunity This is required and must be done immediately in case further vaccinations are needed |
| <input type="checkbox"/> | Hepatitis B Booster or Repeat Series | <ul style="list-style-type: none"> Start immediately <u>ONLY</u> if antibody titer shows no (repeat all 3 doses) or low (get booster dose) immunity. |
| <input type="checkbox"/> | TDAP | <ul style="list-style-type: none"> Proof of TDAP dated within 10 years |
| <input type="checkbox"/> | Influenza Vaccination (<i>Seasonal</i>) | <ul style="list-style-type: none"> Required for all classes |
| PAGE 4 – TB Testing (to be completed by physician or clinical staff) | | |
| <input type="checkbox"/> | Step #1 TB Test Results (must be within 12 months of clinical) | <ul style="list-style-type: none"> 1st TB test must be administered, and results documented 48-72 hours later |
| <input type="checkbox"/> | Step #2 TB Test Results (must be within 3 months of clinical) | <ul style="list-style-type: none"> One week after 1st test is read, have second test administered, and results documented 48-72 hours later |
| <input type="checkbox"/> | IMPORTANT NOTE REGARDING TB TESTING: | |
| | <ul style="list-style-type: none"> QuantiFERON blood testing may be administered in place of the two-step TB testing. QuantiFERON or chest x-ray must be performed in the event of any positive results from the skin testing. | |

NORTHAMPTON COMMUNITY COLLEGE

NCC Health & Wellness Center

Main Campus ♦ College Center ♦ Room 120
3835 Green Pond Road ♦ Bethlehem, PA 18020
Phone: 610-861-5365 ♦ Fax: 610-861-4545

NCC Health & Wellness Center Physical Exam and Health Requirement Options

| | | |
|----------------|---|--|
| Physical Exams | \$25.00 <i>(by appointment only at the Health & Wellness Center)</i> | \$45.00 <i>(at St. Luke's North*)</i> |
|----------------|---|--|

Required Vaccines/Titers

| IMMUNIZATION | VACCINE PRICES | TITER PRICES |
|----------------------------|---|--|
| | <i>Available at both the Health & Wellness Center and St. Luke's North*</i> | <i>Available at St. Luke's North* only</i> |
| Hepatitis A (per dose) | \$65.00 <i>(2 doses needed)</i> | |
| Hepatitis B (per dose) | \$60.00 <i>(3 doses needed)</i> | \$30.00 |
| Meningitis (Menactra) | \$130.00 | |
| MMR (per dose) | \$70.00 <i>(2 doses needed)</i> | \$219.50 <i>(for all 3 titers)</i> |
| Tetanus (Tdap) | \$40.00 <i>(includes pertussis)</i> | |
| Tuberculin Skin Test (PPD) | \$10.00 <i>(per test)</i> | |
| Varicella | \$135.00 | \$42.60 |

** St. Luke's North may also charge an administration fee.*

Pricing subject to change by provider.

- CHE Instructor
- Dental Assisting
- Nursing Reactivation
- Phlebotomy Technician
- Other _____

NORTHAMPTON
COMMUNITY COLLEGE
HEALTH FORM
HEALTHCARE EDUCATION PROGRAMS

For questions about Health requirements, please contact:

Healthcare Education
Northampton Community College
Fowler Family Southside Center
511 E. Third Street, Suite 350K
Bethlehem, PA 18015
Phone: 610-861-4192
healthcare@northampton.edu

PART I - REPORT OF MEDICAL HISTORY

Please complete (print all sections). International students: please provide all health documents translated into English.

Student Name: _____ Student ID #: _____
Last First Middle

Home Address: _____ Gender: Male Female Other _____

City/State/Zip: _____ Preferred: He/Him She/Her They/Them

Home Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____

Program/Major: _____ On Campus Housing: Yes No

Semester: FA SP SU Year _____ Campus: Main Fowler Monroe

I. EMERGENCY NOTIFICATION

Name of Contact: _____ Relationship: _____
 Home Address: _____ City/State/Zip: _____
 Primary Phone: _____ Alternate Phone: _____

II. MEDICAL HISTORY - Please answer yes or no to all questions and insert the year for all positive answers:

| | Yes | No | Please Explain |
|---------------------------|-----|----|----------------|
| Allergies | | | |
| Asthma | | | |
| Cardiac | | | |
| Chemical Dependency | | | |
| ▪ Drugs | | | |
| ▪ Alcohol | | | |
| Diabetes Mellitus | | | |
| Gastrointestinal Disorder | | | |
| Hearing Disorder | | | |
| Hypertension | | | |
| Neuromuscular | | | |
| Orthopedic Condition | | | |
| Respiratory Illness | | | |
| Seizure Disorder | | | |
| Vision Disorder | | | |
| Other (Specify) | | | |

ACCIDENT AND HEALTH INSURANCE (Required) - Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program and must notify the Program Director and the Health and Wellness Center of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

If the above-named emergency contact cannot be reached at the time of an emergency, the College is authorized to send the above-named student to the nearest hospital and/or to administer necessary emergency care. In addition, I authorize the release of information regarding my health/medical status to the Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, and/or to the above-named emergency contact.

 Student signature (Parent/Guardian if under 18 years of age) Date

PART II-REPORT OF MEDICAL EXAMINATION

A physical examination completed within 6 months of the start of the clinical experience by a licensed medical provider (MD, DO, CRNP, or PA-C) is required prior to entry into clinical practice. Clinical work is PROHIBITED until the required medical forms are uploaded and verified.

Name: _____ Student ID: _____ DOB: _____

I. Height _____ Weight _____ Blood Pressure _____ Pulse _____

II. Vision Uncorrected R _____ L _____
 Corrected R _____ L _____

III. Clinical Examination: *Describe details of abnormalities* Date of Examination: _____

| | Normal | Abnormal | Comments |
|----------------------------------|--------|----------|--|
| Skin | | | |
| Head and scalp | | | |
| Eyes | | | |
| Ears/Hearing | | | |
| Mouth, Nose, Throat | | | |
| Neck | | | |
| Heart | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Neurological | | | |
| Psychiatric | | | |
| Exposure to Hepatitis A, B, or C | | | <i>If positive for exposure, please submit titers.</i> |

| | |
|--------------------------------------|--|
| Allergies | |
| Medications taken on a regular basis | |

| **IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING: | INITIALS |
|---|-----------------|
| I certify that the applicant is free from communicable diseases in the communicable state. | |
| I certify that the applicant has no medical conditions or restrictions which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note them in the comments section below.) | |
| Comments (if applicant has any limitations, please explain): | |

Please print, type or stamp:

Name of Licensed Provider _____

Address: _____

Signature of Licensed Provider _____ Date _____

Name: _____
Last First Middle

Student ID # _____

TUBERCULOSIS SCREENING REQUIREMENTS

In order for any student to observe in any area of the Clinical Site, Tuberculosis screening must be administered and documented and may be obtained by skin testing or blood test. Two TB skin tests are required within 12 months, the most recent within 3 months, of the start of your Clinical Experience. A QuantiFERON-TB Gold blood test may be administered within 3 months of the start of your Clinical Experience, in lieu of the two TB skin tests. Document the results below and/or upload relevant documentation.

**** If results are positive (greater than 10mm induration), or if there is any history of a previous positive TB test, either the QuantiFERON-TB Gold blood test or chest x-ray must be performed.**

A. Two TB Skin Tests - within 12 months, the most recent within 3 months, of the start of the clinical experience.

| STEP 1 | Date | Arm | Results (mm) | Signature |
|--------------|------|-----|--|-----------|
| Administered | | | | |
| Results Read | | | <input type="checkbox"/> (+) <input type="checkbox"/> (-) ____mm | |

*** AND ***

| STEP 2 | Date | Arm | Results (mm) | Signature |
|--------------|------|-----|--|-----------|
| Administered | | | | |
| Results Read | | | <input type="checkbox"/> (+) <input type="checkbox"/> (-) ____mm | |

OR -

B. QuantiFERON-TB Gold or T-SPOT-TB blood test - within 3 months of the start of the clinical experience: **MUST UPLOAD COPY OF LAB REPORT.**

OR -

C. Chest X-Ray - within 6 months of the start of the clinical experience: **MUST UPLOAD COPY OF CHEST X-RAY REPORT.**

NOTE: TB testing can be administered at the location of the student's choice (i.e., private physician's office, NCC Health and Wellness Center, or at any clinic.) The student is responsible for any and all charges.

TO BE COMPLETED BY MEDICAL PROVIDER WHEN TB RESULTS ARE VERIFIED:

| | |
|--------------------------------------|------------|
| <i>Please print, type or stamp:</i> | |
| Name of Licensed Provider _____ | |
| Address: _____ | |
| Signature of Licensed Provider _____ | Date _____ |

OSHA INFOSHEET

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method. To facilitate these medical evaluations, this INFOSHEET includes the mandatory medical questionnaire to be used for these evaluations.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Once filled out, this form must be given to the PLHCP. This form should not be submitted to OSHA.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex: Male Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire: Yes No
11. Check the type of respirator you will use (you can check more than one category):
 - a. N, R, or P disposable respirator (filter-mask, non-cartridge type only).
 - b. Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes No If "yes," what type(s):

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

| | YES | NO |
|---|-----------------------|-----------------------|
| 1. Do you <i>currently</i> smoke tobacco, or have you smoked tobacco in the last month? | <input type="radio"/> | <input type="radio"/> |
| 2. Have you <i>ever had</i> any of the following conditions? | | |
| a. Seizures | <input type="radio"/> | <input type="radio"/> |
| b. Diabetes (sugar disease) | <input type="radio"/> | <input type="radio"/> |
| c. Allergic reactions that interfere with your breathing | <input type="radio"/> | <input type="radio"/> |
| d. Claustrophobia (fear of closed-in places) | <input type="radio"/> | <input type="radio"/> |
| e. Trouble smelling odors | <input type="radio"/> | <input type="radio"/> |
| 3. Have you <i>ever had</i> any of the following pulmonary or lung problems? | | |
| a. Asbestosis | <input type="radio"/> | <input type="radio"/> |
| b. Asthma | <input type="radio"/> | <input type="radio"/> |

| | YES | NO |
|---|-----------------------|-----------------------|
| c. Chronic bronchitis | <input type="radio"/> | <input type="radio"/> |
| d. Emphysema | <input type="radio"/> | <input type="radio"/> |
| e. Pneumonia | <input type="radio"/> | <input type="radio"/> |
| f. Tuberculosis | <input type="radio"/> | <input type="radio"/> |
| g. Silicosis | <input type="radio"/> | <input type="radio"/> |
| h. Pneumothorax (collapsed lung) | <input type="radio"/> | <input type="radio"/> |
| i. Lung cancer | <input type="radio"/> | <input type="radio"/> |
| j. Broken ribs | <input type="radio"/> | <input type="radio"/> |
| k. Any chest injuries or surgeries | <input type="radio"/> | <input type="radio"/> |
| l. Any other lung problem that you've been told about | <input type="radio"/> | <input type="radio"/> |
| 4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness? | | |
| a. Shortness of breath | <input type="radio"/> | <input type="radio"/> |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | <input type="radio"/> | <input type="radio"/> |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | <input type="radio"/> | <input type="radio"/> |
| d. Have to stop for breath when walking at your own pace on level ground | <input type="radio"/> | <input type="radio"/> |
| e. Shortness of breath when washing or dressing yourself | <input type="radio"/> | <input type="radio"/> |
| f. Shortness of breath that interferes with your job | <input type="radio"/> | <input type="radio"/> |
| g. Coughing that produces phlegm (thick sputum) | <input type="radio"/> | <input type="radio"/> |
| h. Coughing that wakes you early in the morning | <input type="radio"/> | <input type="radio"/> |
| i. Coughing that occurs mostly when you are lying down | <input type="radio"/> | <input type="radio"/> |
| j. Coughing up blood in the last month | <input type="radio"/> | <input type="radio"/> |
| k. Wheezing | <input type="radio"/> | <input type="radio"/> |
| l. Wheezing that interferes with your job | <input type="radio"/> | <input type="radio"/> |
| m. Chest pain when you breathe deeply | <input type="radio"/> | <input type="radio"/> |
| n. Any other symptoms that you think may be related to lung problems | <input type="radio"/> | <input type="radio"/> |
| 5. Have you <i>ever had</i> any of the following cardiovascular or heart problems? | | |
| a. Heart attack | <input type="radio"/> | <input type="radio"/> |
| b. Stroke | <input type="radio"/> | <input type="radio"/> |
| c. Angina | <input type="radio"/> | <input type="radio"/> |
| d. Heart failure | <input type="radio"/> | <input type="radio"/> |

| | YES | NO |
|---|-----------------------|-----------------------|
| e. Swelling in your legs or feet (not caused by walking) | <input type="radio"/> | <input type="radio"/> |
| f. Heart arrhythmia (heart beating irregularly) | <input type="radio"/> | <input type="radio"/> |
| g. High blood pressure | <input type="radio"/> | <input type="radio"/> |
| h. Any other heart problem that you've been told about | <input type="radio"/> | <input type="radio"/> |
| 6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms? | | |
| a. Frequent pain or tightness in your chest | <input type="radio"/> | <input type="radio"/> |
| b. Pain or tightness in your chest during physical activity | <input type="radio"/> | <input type="radio"/> |
| c. Pain or tightness in your chest that interferes with your job | <input type="radio"/> | <input type="radio"/> |
| d. In the past two years, have you noticed your heart skipping or missing a beat | <input type="radio"/> | <input type="radio"/> |
| e. Heartburn or indigestion that is not related to eating | <input type="radio"/> | <input type="radio"/> |
| f. Any other symptoms that you think may be related to heart or circulation problems | <input type="radio"/> | <input type="radio"/> |
| 7. Do you <i>currently</i> take medication for any of the following problems? | | |
| a. Breathing or lung problems | <input type="radio"/> | <input type="radio"/> |
| b. Heart trouble | <input type="radio"/> | <input type="radio"/> |
| c. Blood pressure | <input type="radio"/> | <input type="radio"/> |
| d. Seizures | <input type="radio"/> | <input type="radio"/> |
| 8. If you've used a respirator, have you <i>ever had</i> any of the following problems? (If you've never used a respirator, check the following space and go to question 9.) <input type="checkbox"/> | <input type="radio"/> | <input type="radio"/> |
| a. Eye irritation | <input type="radio"/> | <input type="radio"/> |
| b. Skin allergies or rashes | <input type="radio"/> | <input type="radio"/> |
| c. Anxiety | <input type="radio"/> | <input type="radio"/> |
| d. General weakness or fatigue | <input type="radio"/> | <input type="radio"/> |
| e. Any other problem that interferes with your use of a respirator | <input type="radio"/> | <input type="radio"/> |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? <input type="checkbox"/> | | |
| Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary. | | |
| 10. Have you <i>ever</i> lost vision in either eye (temporarily or permanently)? | <input type="radio"/> | <input type="radio"/> |
| 11. Do you <i>currently</i> have any of the following vision problems? | <input type="radio"/> | <input type="radio"/> |
| a. Wear contact lenses | <input type="radio"/> | <input type="radio"/> |
| b. Wear glasses | <input type="radio"/> | <input type="radio"/> |
| c. Color blind | <input type="radio"/> | <input type="radio"/> |
| d. Any other eye or vision problem | <input type="radio"/> | <input type="radio"/> |

| | YES | NO |
|--|-----------------------|-----------------------|
| 12. Have you <i>ever had</i> an injury to your ears, including a broken eardrum? | <input type="radio"/> | <input type="radio"/> |
| 13. Do you <i>currently</i> have any of the following hearing problems? | <input type="radio"/> | <input type="radio"/> |
| a. Difficulty hearing | <input type="radio"/> | <input type="radio"/> |
| b. Wear a hearing aid | <input type="radio"/> | <input type="radio"/> |
| c. Any other hearing or ear problem | <input type="radio"/> | <input type="radio"/> |
| 14. Have you <i>ever had</i> a back injury? | <input type="radio"/> | <input type="radio"/> |
| 15. Do you <i>currently</i> have any of the following musculoskeletal problems? | <input type="radio"/> | <input type="radio"/> |
| a. Weakness in any of your arms, hands, legs, or feet | <input type="radio"/> | <input type="radio"/> |
| b. Back pain | <input type="radio"/> | <input type="radio"/> |
| c. Difficulty fully moving your arms and legs | <input type="radio"/> | <input type="radio"/> |
| d. Pain and stiffness when you lean forward or backward at the waist | <input type="radio"/> | <input type="radio"/> |
| e. Difficulty fully moving your head up or down | <input type="radio"/> | <input type="radio"/> |
| f. Difficulty fully moving your head side to side | <input type="radio"/> | <input type="radio"/> |
| g. Difficulty bending at your knees | <input type="radio"/> | <input type="radio"/> |
| h. Difficulty squatting to the ground | <input type="radio"/> | <input type="radio"/> |
| i. Climbing a flight of stairs or a ladder carrying more than 25 lbs. | <input type="radio"/> | <input type="radio"/> |
| j. Any other muscle or skeletal problem that interferes with using a respirator | <input type="radio"/> | <input type="radio"/> |

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of

Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

This InfoSheet is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The *Occupational Safety and Health Act* requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.



U.S. Department of Labor



NORTHAMPTON COMMUNITY COLLEGE

FIT TEST MEDICAL CLEARANCE

OSHA Form Review

Healthcare Education Programs

Name: _____
Last First Middle

DOB: _____ Student ID: _____

| | Program of Study | | Healthcare Education Instructor |
|--------------------------|-------------------------|--------------------------|--|
| <input type="checkbox"/> | Dental Assisting | <input type="checkbox"/> | Nurse Aide Instructor |
| <input type="checkbox"/> | Nursing Reactivation | <input type="checkbox"/> | Nursing Reactivation Instructor |
| <input type="checkbox"/> | Phlebotomy | <input type="checkbox"/> | Phlebotomy Instructor |
| <input type="checkbox"/> | | <input type="checkbox"/> | |

I hereby certify that I have reviewed the attached OSHA Form for the above-named individual, and this individual is medically cleared to be fit tested for a N95 respiratory face mask.

To be completed by medical provider:

| | |
|---------------------------------------|-------------|
| Please print, type, or stamp: | |
| Name of Licensed Provider: _____ | |
| Address: _____ | |
| Phone: _____ | |
| Signature of Licensed Provider: _____ | Date: _____ |

URINE DRUG SCREENING REQUIREMENTS

NCC's Allied Health programs are affiliated with healthcare providers throughout the region. A number of these facilities now require students participating in clinical education at their site to have drug screens completed prior to attending clinical.

When do I go for my drug screen?

At a later date to be determined, you will be given information and dates to have your drug screen done. **YOU WILL ONLY BE GIVEN 24-48 HOURS' NOTICE.** This may be done during class, or you may be required to go to St. Luke's North or another facility. If it is done during class and you are absent on the day of testing, you will be required to go to St. Luke's North by the end of that same business day. It is important that you obtain your drug test in the specified time frame in order for St. Luke's to process and deliver the results in a timely manner.

Where do I go to have the drug screen done?

St. Luke's North is our preferred provider for these drug screens, and they are aware of NCC Allied Health student requirements. The test may be performed during class or at their site at NCC's discretion, and St. Luke's will communicate the results directly to the NCC authorized NCC Staff. Allied Health program directors will communicate with the authorized NCC staff to ensure that all students are compliant with the requirement and all student results are negative.

What should I bring with me?

You should bring the drug screen form that will be given to you in class, as well as photo identification and payment.

What is the cost of the test?

The current cost* of the test is \$34 and is due at time of service. Payment may be made by cash or check payable to St. Luke's. *****Cost is subject to change during the course of the academic year.*****

What if my drug screen is positive?

Students will only be permitted to attend clinical education if they have a negative drug screen. Any student with a positive screen will be immediately withdrawn from the program.

What if my provider has prescribed Medical Marijuana?

NCC has a policy for addressing the use of medical marijuana that you are able to read prior to enrolling in this program so that you are aware of the policy and its potential effects of your ability to complete this program.

REMINDER: Plan now so that you have your payment money available at any time but DO NOT OBTAIN DRUG SCREEN NOW!

Health Careers Medical Marijuana Policy

In order to be transparent regarding the entire drug screening process and the use of Medical Marijuana, Northampton Community College recognizes our responsibility to fully inform students of NCC's policy at the time of acceptance. Please read the following policy carefully and acknowledge your understanding by signing and uploading this form to myRecordTracker.

The Pennsylvania Department of Health is currently implementing the Pennsylvania Medical Marijuana Program, a component of the Medical Marijuana Act (MMA) that was signed as law on April 17, 2016. This program provides access to medical marijuana for patients with serious medical conditions as defined by the Pennsylvania Department of Health.

At this time, the Federal government regulates drugs through the Controlled Substances Act, which does not recognize the difference between medical and recreational use of marijuana. Under Federal law, marijuana is a Schedule 1 controlled substance, meaning that it is considered to have no medical value. Medical practitioners may not prescribe marijuana for medical use under Federal law.

Students entering any Health Science Careers Program are required to have urine drug screenings upon admission to the clinical phase of the program and on a yearly basis while participating in clinical experiences. As per current policy, if the results are positive, the student will be dismissed from the program immediately and referred for appropriate counseling.

Students using medical marijuana will not be eligible for clinical, internship, or externship placement in any NCC health science career program, due to the current discrepancy between State and Federal law regarding Drug Free Work Place Act and the MMA. Businesses who are not in compliance with Federal law are at risk for criminal or civil charges; and additionally, may find issue with eligibility for Federal contracts and grants. Additionally, Pennsylvania's Medical Marijuana statute specifically provides that an employer does not have to accommodate an individual in a safety sensitive position if that person is under the influence of medical marijuana. Most positions involving direct patient care will be considered safety sensitive positions.

Students should also understand that under current Pennsylvania State Board law, many health career licensing boards require drug screening at the time of application for licensure. Similarly, most health care employers will perform routine drug screening as a condition for employment, as these positions involve direct patient care, and are considered safety sensitive positions. **This discrepancy between Federal and State law allows our clinical partners to deny student placement for clinical experiences and the State of Pennsylvania to deny licensure.**

Due to current laws, NCC cannot provide admission to the clinical phase in any of our Health Science Career Programs and students who have been admitted and are later to be found positive for medical marijuana will be dismissed from the Program.

I hereby acknowledge that I have read and understand NCC's Health Careers Medical Marijuana Policy.

Student's Name (Please Print)

Signature of Student

Date

NORTHAMPTON
COMMUNITY COLLEGE

Healthcare Education

STUDENT EMERGENCY CONTACT INFORMATION

Please print clearly:

Student Name: _____

Preferred or Chosen Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT(S):

Name: _____

Relationship to Student: _____

Phone: _____ Alternate Phone: _____

Name: _____

Relationship to Student: _____

Phone: _____ Alternate Phone: _____

MEDICAL INFORMATION:

Medical Conditions: _____

Known Allergies to Medications: _____

Other Conditions to be aware of: _____

Hospital Preference: _____

In the event of an emergency, please contact:

Eileen Truscott
Associate Director, Healthcare Education
Northampton Community College

Office Phone: 610-332-6585
Cell Phone: 610-217-6049
E-mail: etruscott@northampton.edu

NORTHAMPTON

COMMUNITY COLLEGE

NURSING REACTIVATION/REVIEW PROGRAM STUDENT AGREEMENT

Northampton Community College recognizes that you may need to be excused from class due to an acute illness for yourself or a dependent, death of an immediate family member, or a court order.

- ✓ You must notify your instructor prior to the start time of class if you are going to be tardy or absent.
- ✓ You must submit documentation for your absence, such as a physician's excuse, death notice, or documentation from a court appearance. Documentation must be received before you will be allowed to take the final exam or make up days.
- ✓ You are required by the Pennsylvania State Board of Nursing continuing education approval unit to complete 60 hours of theory and 120 hours of clinical for Registered Nurses and 44 hours of theory and 80 hours of clinical for Licensed Practical Nurses before you are issued your certification of completion. Therefore, you must make up all absences, including any time you are tardy. Your instructor, before the conclusion of the program, must schedule the make-up days. All make up days must be completed within seven (7) days from the last day of the program in which you were enrolled.
- ✓ Northampton Community College will allow a maximum of two (2) make-up days. If you are absent for more than two days, you must be dismissed from the program. If you require clinical make-up days and cannot attend during the current session, you will be charged \$250 per day for a maximum of two (2) days for a total of \$500. Clinical make-up days must be scheduled and paid for prior to the beginning of the make-up session.
- ✓ I have read and completed the following forms:
 - Signed this form after reading and understanding the policies and procedures.
 - Have received a copy of the Northampton Community College Nursing Reactivation/Review Student Handbook.
 - Have received a copy of the syllabus and understand my responsibilities as a student in order to successfully complete the program.

I have read and understand the above policies and procedures for the Northampton Community College Nursing Reactivation/Review Program. I also agree to take the standardized comprehensive exam at the completion of the program, if required, to obtain re-licensure.

Student's Name (*PLEASE PRINT*)

Student's Signature

Date

Original: Permanent File

NORTHAMPTON
COMMUNITY COLLEGE

FELONY DISCLOSURE FORM

The following information is very important for RN and LPN Nursing Reactivation students. Although this does not affect students until they complete their education and apply for licensure, Northampton Community College, Healthcare Education Department requires proof (by your signature) that you were notified of this law prior to starting the program. Please read this information carefully, sign, and return this document to: Northampton Community College, Healthcare Education, Fowler Center – Suite 350, 511 E. Third St., Bethlehem, PA, 18015, on the first day of class.

Act 1985-109 and Act 1985-110 known as the Professional Nursing Law and Practical Nursing Law of the Laws of Pennsylvania declares the following:

“...The Board shall not issue a license or certificate to an applicant who has been convicted of a felonious act prohibited by the act of April 14, 1972 (P.L. 233, no. 64) known as “The Controlled Substance, Drug, Device and Cosmetic Act”, or convicted of a felony relating to a controlled substance in a court of law of the United States or any other state, territory, or country unless:

- (1) at least ten (10) years have elapsed from the date of conviction;
- (2) the applicant satisfactorily demonstrates to the board that she/he has made significant progress in personal rehabilitation since the conviction such that licensure of the applicant should not be expected to create a substantial risk of harm to the health and safety of patients or the public or a substantial risk of criminal violations; and
- (3) the applicant otherwise satisfies the qualifications contained in or authorized by this act.

As used in this section the term “convicted” shall include a judgment, an admission of guilt, or a plea of nolo contendere. An applicant’s statement on the application declaring the absence of a conviction shall be deemed satisfactory evidence of a non-conviction, unless the board has some evidence to the contrary.”

Your signature below indicates that you have read and understand the above excerpts from the Professional and Practical Nurse Laws known as Acts 1985-109 and 1985-110.

Print Name

Signature

Date

NORTHAMPTON

COMMUNITY COLLEGE

Basic Life Support

Section S

Basic Life Support for Healthcare Providers (BLS)

Please provide a copy of your current BLS card. If you do not have that certification, courses are available through NCC at <http://www.northampton.edu/cpr>, click on Basic Life Support and register for CPRFA100, Basic Life Support for Healthcare Providers. This certificate is also available through the American Heart Association at www.americanheart.org. Online courses are not acceptable.

NORTHAMPTON
COMMUNITY COLLEGE

PLEASE READ, SIGN AND UPDATE FORMS TO MyRecordTracker:

_____ **Covid 19 Policy**

_____ **Privacy and Confidentiality**

_____ **Permission for the Release of Student Information**

_____ **Photography / Video Release**

_____ **Confidentiality Agreement**

NORTHAMPTON COMMUNITY COLLEGE

NCC HEALTH SCIENCES/HEALTHCARE EDUCATION COVID-19 POLICY

1. Proof of a COVID-19 vaccination (one dose J & J, or two doses of Pfizer or Moderna) is mandatory for all students. Proof will be uploaded to myRecordTracker.
2. If you are not feeling well/experiencing any COVID-related symptoms, stay home! Be sure to notify your instructor, as well as your preceptor/manager, if applicable, as you have been instructed to during orientation with as much notice as possible.
3. Students and instructors are encouraged to wear a mask while on NCC property. Please be considerate of those around you and wear a mask if requested by your instructor or another student. Masks are available at building and classroom entrances, along with hand sanitizer.
4. NCC instructors and students should wear their NCC ID badge while on NCC property.
5. Students who need to be dismissed from class due to COVID-19 symptoms or for coming in contact with a person who tested positive for COVID-19:
 - a. Student will be instructed to go home, isolate, and call their health care provider.
 - b. If student has a negative COVID-19 test, they will be required to share results with NCC.
 - c. If student has a positive COVID-19 test, they are required to report test results to the NCC Health Center at 610-861-5365.
 - d. If student has a positive COVID-19 test, they will be required to provide proof of a negative COVID-19 test prior to returning to class and/or clinical.
 - e. Students that cannot finish their class/program due to COVID-19 will be brought back into the next available class/course and can continue where they left off when possible. If this occurs during clinical or externship, next steps may be determined by the protocols of the facility.
6. NCC instructors and students will adhere to these policies at all times while at NCC and adhere to facility policies during clinical rotation, which may include wearing a mask at all times, safety glasses and other PPE, as required by the clinical site.
7. Students may be required to have a COVID-19 test prior to clinical rotation if requested by the facility. If so, students will be responsible for the out-of-pocket expenses for the testing.
 - a. Students may not be allowed to enter clinical site without proof of a negative COVID-19 test.
 - b. Remember that a negative COVID-19 test today does not mean that you cannot contract COVID-19 tomorrow!

I have read and agree to abide by the aforementioned policy related to COVID-19:

Student's Name (PLEASE PRINT) _____

Student's Signature _____ Date _____

NORTHAMPTON COMMUNITY COLLEGE

PRIVACY AND CONFIDENTIALITY Photographing, Recording, and Social Media of Patients/Residents/Clients/Consumers and Their Families, Including Clinical Site Staff, Instructors, and Classmates

According to Federal requirements related to abuse at F223 and F226 “the patient/resident/client/consumer”, has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.” “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of the patient/ resident/client/consumer and misappropriation of patient/resident/client/ consumer property.”

- ⦿ **Under no circumstances is it acceptable for a student or instructor to take photos, record sounds/voices or video of any patient/resident/client/consumer that contains nudity or shows the resident in a negative way.** This includes the following: bathing, showering, toileting, incontinence care, perineal care, showing a body part without the patient’s/resident’s/client’s/consumer’s face whether it is the chest, limbs, or back, inappropriate behavior by a patient/resident/client/consumer, or anything showing the patient/resident/client/consumer in a compromised position.
- ⦿ **Under no circumstances is it acceptable for a student or instructor to post any photos, record sounds/voices, video, or any other information regarding any patient/resident/client/consumer on any social media platform.**
- ⦿ Surveyors must investigate these incidents regardless of the cognitive status or consent of the patient/resident/client/consumer.
- ⦿ It is also unacceptable to photograph or record patient’s/resident’s/client’s/consumer’s family members, clinical site staff, your instructors, and classmates.
- ⦿ If students ask to take pictures or record lectures (in the classroom and/or skills lab) for the sole purpose of learning and studying, it is at the instructor’s discretion whether or not a student has their permission.
- ⦿ Students may have their photographs taken for the purpose of creating ID badges, as required by our clinical sites. Your photos are kept on file for our recordkeeping and will not be used in any other way, without the student’s consent.
- ⦿ You may be asked to sign a Photography Release if classroom photographs are taken for the use of college marketing materials.

I have read and understand the above policy regarding privacy and confidentiality and agree to adhere to this policy and realize that I may be withdrawn from the program for any violations of this policy.

Name of Student (PLEASE PRINT)

Signature of Student

Date

Original: Permanent File

NORTHAMPTON COMMUNITY COLLEGE

PERMISSION FOR THE RELEASE OF STUDENT INFORMATION

STUDENT NAME *(Please print)*: _____

I hereby give Northampton Community College, Nursing Reactivation/Review Program permission to release information to:

_____ Prospective Employers
_____ CareerLink
_____ Clinical Facilities

The following categories may be released for the purpose of referral or information:

| | | |
|----------------------|------------------------------|-----------------------------|
| Test Data | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal Information | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Academics | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I hereby authorize Northampton Community College Nursing Reactivation/Review Program to release a copy of my competencies to prospective employers/agencies who request training information.

Date: _____ Signature: _____

Northampton Community College ♦ Healthcare Education ♦ Fowler Family Southside Center
511 E. Third Street ♦ Suite 350 ♦ Bethlehem, PA 18015 ♦ 610-332-6585

NORTHAMPTON COMMUNITY COLLEGE

PHOTOGRAPHY/VIDEO RELEASE

For and in consideration of my engagement as a model by Northampton Community College, Hereafter referred to as NCC, I hereby give NCC, its legal representatives and assigns, those for whom NCC is acting, and those acting with its permissions, or its employees, the right and permission to copy-right and/or use, reuse and/or publish, and republish photographic pictures or portraits or video of me, or in which I may be distorted in character, or form, in conjunction with my own or a fictitious name, on reproductions thereof in color, or black and white made through any media by NCC, for any purpose whatsoever; including the use of any printed matter in conjunction therewith.

I hereby waive any right to inspect or approve the finished photograph, video or advertising copy or printed matter that may be used in conjunction therewith or to the eventual use that I might be applied.

I hereby release, discharge and agree to save harmless NCC, its representatives, assigns, employees or any person or persons, corporation or corporations, acting under its permission or authority, or any person, persons, corporation or corporations, for whom he/she might be acting, including any firm publishing and/or as a result of any distorting, blurring, or alteration, optical illusion, or use in the taking, processing or reproduction of the finished product, its publication or distribution of the same, even should the same subject me to ridicule, scandal, reproach, scorn or indignity.

- I hereby warrant that I am 18 years of age or older, and competent to contract in my own name insofar as the above is concerned.
- I have read the foregoing release, authorization and agreement, before affixing my signature below, and warrant that I fully understand the contents thereof, and hereby give permission for my photograph to be taken and used as described above.
- I have read the above release, and DO NOT give permission for my photograph to be taken during the course of this program.

Program or Course: RN/LPN Reactivation or Practice Review Course

Print Name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

NORTHAMPTON COMMUNITY COLLEGE

CONFIDENTIALITY AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that all patient information will not be shared with any unauthorized individuals. Students will come in contact with privileged and confidential patient information, both written and oral, in the course of the Externship. It is imperative that this information is not disclosed to any third party or unauthorized individual to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently an employee of the practice. Any other disclosures may only occur at the direction and discretion of the Clinical Affiliate or by patient authorization.

Please remember that privacy and confidentiality also include the use of cell phones and taking photos or recording during clinical rotations as discussed in the Privacy and Confidentiality Acknowledgment. Be mindful of patients' and families' rights and privacy when taking photos, recording, or speaking on your cell phone during externship.

I have read and understand the policies relating to privacy and patient confidentiality. I agree to maintain confidentiality of all information obtained during the course of the Northampton Community College Nursing Reactivation/Review Program. I understand that inappropriate disclosure or release of patient information is grounds for immediate dismissal from the Program.

Student's Name (PLEASE PRINT) _____

Student's Signature _____ Date _____

Permanent File- Original

NORTHAMPTON
COMMUNITY COLLEGE

Please upload your Nursing License to MyRecordTracker



MYRECORDTRACKER

STUDENT GUIDE

IMPORTANT NOTICE

- ◆ Although you should begin obtaining all of your requirements immediately, you will not be able to upload them until you have received an email from myRecordTracker@VerticalScreen.com with instructions on creating your account, **which may take three to four weeks from notice of your acceptance.**
- ◆ Please check your spam folder if you do not receive the email within this timeframe.
- ◆ Use **1/1/2099** when prompted for an expiration date.
- ◆ If you are a student in an Allied Health major **and** living in the Residence Halls, you will be required to use **both your NCC Student email address and a personal email address in order to create TWO separate myRecordTracker® accounts.**
- ◆ If you have questions regarding the email accounts, please contact the NCC Technology Services Help Desk at 610-861-5413 or helpdesk@northampton.edu.

EMPOWERED BY  VERTICAL SCREEN

Proprietary information. Property of Certiphi Screening, Inc.
This confidential information is not to be shared with any party outside of your department/company without the written consent of Certiphi Screening, Inc.

WELCOME

This guide will provide you with clear, concise step-by-step instructions for accessing myRecordTracker to upload and share documentation pertaining to your student requirements. If you have questions about myRecordTracker, please contact Certiphi Screening's Applicant Services team at 800-735-2660, ext. 2006 or myrecordtracker@verticalscreen.com.

STEP 1: EMAIL NOTIFICATION

You will receive an email notification from myrecordtracker@verticalscreen.com with important instructions on how to access and create a myRecordTracker account. The following is a sample email that you will receive to initiate the record fulfillment process.

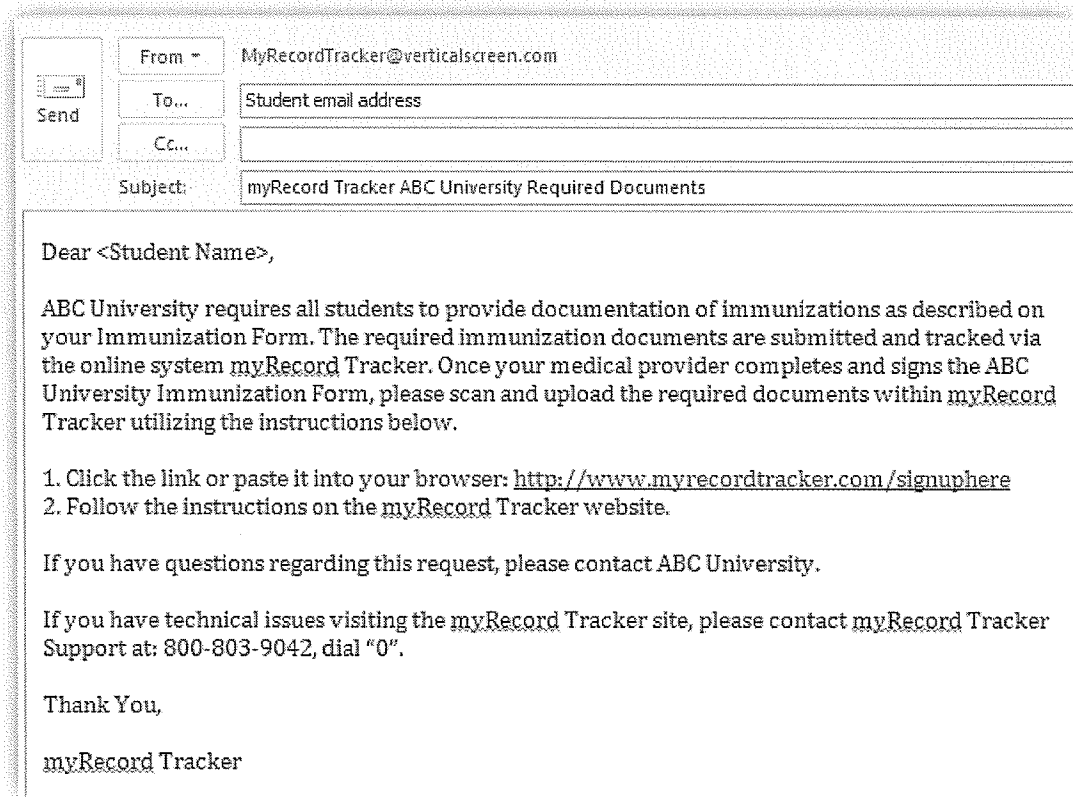


Figure 1: Sample email from school

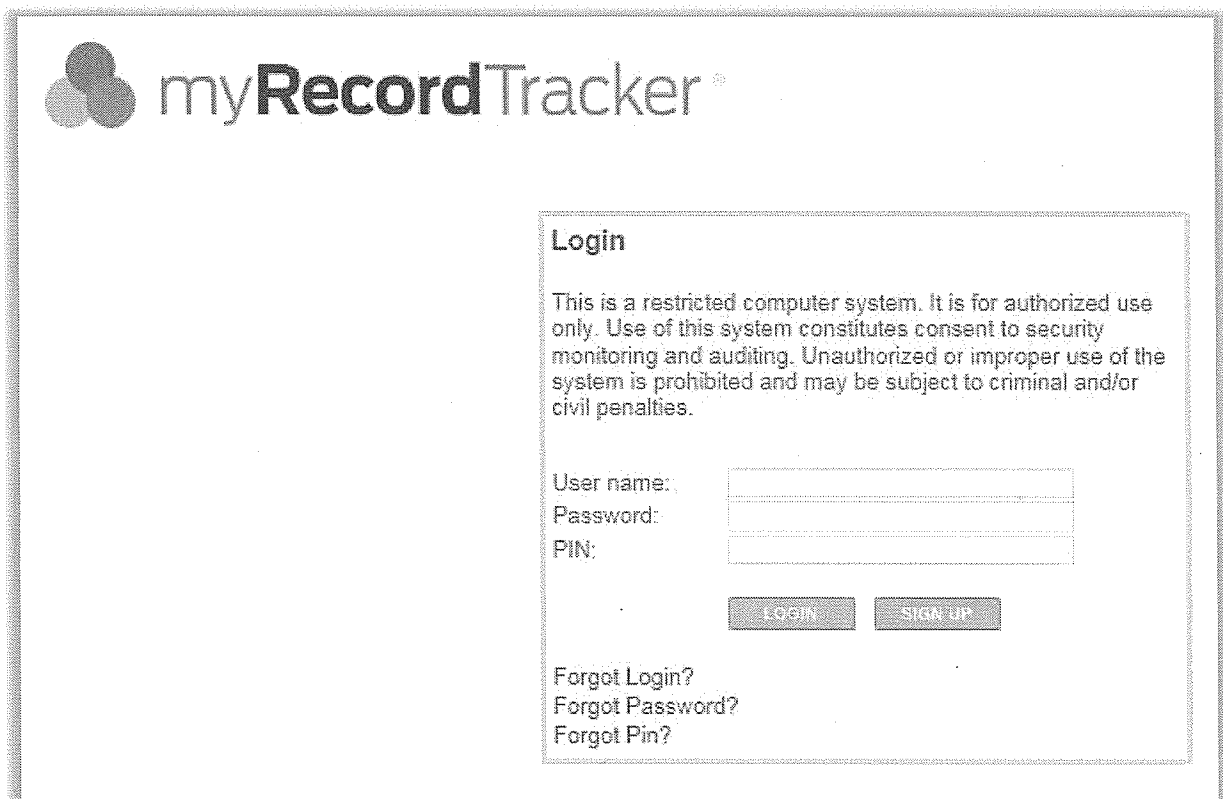
NOTE: In order for you to receive the invitation email from myRecordTracker, the school must have uploaded your contact information into the myRecordTracker system. If you are expecting an invitation email to myRecordTracker, but you have not received one, contact the school.

The myRecordTracker invitation email will prompt you to use the link provided to create a myRecordTracker account. Once you create an account, you can begin fulfilling the program requirements.

NOTE: Please do not share the URL included in the invitation email. The URL is only available for one-time use to set up your profile and is unique to your particular profile and requirements.

STEP 2: ACCESSING MYRECORDTRACKER

Once your myRecordTracker account is created, you can log in to gain access to your account by visiting www.myrecordtracker.com and entering your username, password and PIN.



The screenshot shows the myRecordTracker login interface. At the top left is the myRecordTracker logo, consisting of three overlapping circles and the text "myRecordTracker". Below the logo is a "Login" section. This section contains a disclaimer: "This is a restricted computer system. It is for authorized use only. Use of this system constitutes consent to security monitoring and auditing. Unauthorized or improper use of the system is prohibited and may be subject to criminal and/or civil penalties." Below the disclaimer are three input fields labeled "User name:", "Password:", and "PIN:". To the right of these fields are two buttons: "LOGIN" and "SIGN UP". At the bottom of the login section are three links: "Forgot Login?", "Forgot Password?", and "Forgot Pin?".

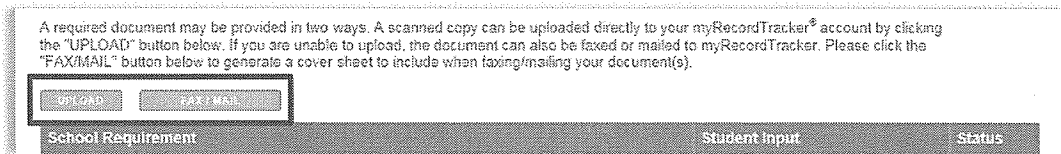
Figure 2: The myRecordTracker login screen

How to Complete Your myRecordTracker Requirements

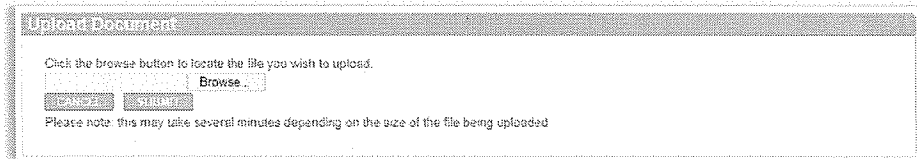
Each requirement within your myRecordTracker profile requires a response in the student input section. If a document is required, please provide a completed copy of the document. If a question is asked, please respond to the question asked. Once a requirement is met, you will see "Pending Approval" appear in the status column. Once the requirement is approved, the requirement status will show as "completed". * It is necessary that all requirements are completed by the due date indicated within the profile.

A required document may be provided in two ways.

- A scanned copy can be uploaded directly to your myRecordTracker account by clicking the "UPLOAD" button below.
- If you are unable to upload, the document can also be faxed or mailed to Certiphi Screening. Please click the "FAX/MAIL" button below to generate a cover sheet to include when faxing/ mailing document(s).



If applicable, the opportunity also exists to attach a single document to multiple requirements. If you choose to upload your document, you will be directed to the Upload Document section of the website (shown below). This will allow you to select and submit the necessary document:



Once submitted, you will be given the opportunity to review the document that was uploaded, along with naming the document on the myRecordTracker website. This section will indicate which unfulfilled requirement(s) are left. You can decide to attach your document to multiple requirements or just one requirement by checking the box to the left of the unfulfilled requirement.

**When prompted
for an expiration
date, please use
1/1/2099**

