Surgical Technology Registration Steps

1. **Potential students will collect the Surgical Technology Packet from the Receptionist or print online.**
2. **Potential students must submit Official Transcripts for evaluation of completed pre-requisites. These transcripts need to be given or emailed to the PC or Dean for review. Contact information can be found below.**
3. **If the pre-requisites are approved, the potential student will be contacted by the PC and told to complete the registration form, submit a picture ID, SSN Card, signed criminal disclosure form and signed approval to register form to the front desk of any campus.**
4. **The front Desk and or PC will share Orientation Dates at the completion of the required registration. Attendance at orientation is mandatory.**
5. **Students must complete the health form within 1 month of beginning the course. (not required to register)**
6. **Students must complete/update all immunizations within 1 month of beginning the course. (not required to register)**
7. **Students must be CPR certified by the end of the Level I Surgical Technology class. (not required to register)**

Questions or Concerns?

Contact:

Charlotte Fike, Surgical Tech Program Coordinator, 910-410-1972, ctfike@richmondcc.edu
Whittney Garner, Clinical Coordinator, 910-410-1973, wgarner@richmondcc.edu
Dr. Qunna Morrow, Dean of Allied Health, 910-410-1751 qmorrow@richmondcc.edu

Serving Richmond and Scotland Counties

Surgical Technology Checklist for: _____

Forms	Yes	No
Registration Form		
Picture ID		
Signed Social Security Card		
Official Transcript: (Required Prior to Completing Registration) ***Approval to Register Form Required***		
Immunization records: (complete within 1st month of class) **MMR x 2** **Hep B x 3** **Varicella x 2** **Tdap (within 10 years)** **Flu vaccine (seasonal)** **COVID vaccine** **TB Skin Test Results**		
Medical Form (complete within 1st month of class)		
BLS-CPR Card (Currently active, needed by end of Level I course		
Criminal Disclosure Form		

GRADES:

Lecture Test 1	
Lecture Test 2	
Midterm	
Written Final	
Lab Test 1	
Lab Test 2	
Practical Final	

_____ _____

Signature of instructor who verified folder Date

Instructions for Completion of the Student Medical Form

The information provided in this health form by the student and the health care provider is confidential and protected by the Health Insurance Portability and Accountability Act Privacy Rule.

1. The student must complete and sign the Personal and Family History prior to the physical exam.
2. The student should complete the immunization requirements and must provide the school with documentation of any immunizations, titers, or screening tests done prior to the current physical exam. If new immunizations, blood tests, or screening tests are done during the physical exam visit, the health care provider must document, initial those, and sign the immunization summary.
3. Students who are providing titers showing immunity in lieu of a vaccination record must submit the laboratory result documenting the titer.
4. Students claiming a disease history in lieu of any vaccinations and titers must provide the record from the medical facility where the disease was originally diagnosed and treated.
5. The health care provider must complete and sign the physical exam form.

Instructions regarding immunizations and health screening tests
To protect both you and your patients, our clinical agencies require the following immunizations and health screening tests. To attend clinical rotations, you must provide all the required information unless you have a documented medical contraindication. Use the following checklist to confirm that you have provided all required information regarding immunizations and health screening tests.

_____ Measles, mumps, rubella (MMR)
Unless you were born before 1957, you must provide the following:
• Two MMR vaccinations after your first birthday OR Titers showing immunity to each of the three disorders

_____ Varicella
• Two varicella vaccines OR Titer showing immunity (Surg Tech will need a Positive titer for clinical requirements).

_____Tetanus/diphtheria (TD) or adult tetanus/diphtheria/pertussis (Tdap)
• You must have a documented tetanus booster within the past 10 years.

_____ Tuberculosis screening
• You must have documented TB screening within the past 12 months. If there is no previous TB screening documented, a 2 Step Test (TST) is required. The 2-Step must be completed within the recommended timeframe of 4 weeks.

• If you have no history of positive screening, you must have a PPD placed and read within 72 hours OR a Quantiferon Gold OR T-spot blood test.

• If you have had a positive screening, you must show documentation of
o A chest X-ray OR The current North Carolina Department of Health and Human Services recommended screening for previous positive PPD signed by a health care provider.

_____ Hepatitis B
• A series of 3 hepatitis B immunizations AND:

• A titer showing immunity (Dental Programs require a quantitative result)
• If you have completed a series of 3 vaccines and are still non-immune, you are required to: Get a fourth hepatitis vaccine AND obtain a titer 4 to 6 weeks after that vaccine.

• If you are still non-immune you may:
o Sign a waiver saying that you do not wish to have more vaccines and understand that you may be susceptible to hepatitis B OR Obtain two more vaccines to complete a second series of 3, which may be followed in 4 to 6 weeks by a titer. (The CDC cites a significant increase in seroconversion when this option is chosen, but seroconversion is not 100%.)

• Since the series and titers take an extended period, you may be mid-process when clinicals begin. Provide all documentation that you have. Your Department Head will give you interim instructions.

Influenza
• Influenza immunization is not part of your fall admission requirements, but you will be required to receive the vaccine annually during the flu season unless you have a documented medical contraindication or religious objection. Declination of influenza may result in inability to participate and complete clinical requirements. You will be informed of the appropriate time to receive this vaccination.

COVID-19
• The COVID-19 vaccination is not required by hospitals surrounding RCC for participation in clinical requirements. The hospital will have the final decision if there are any exemptions or changes to this requirement. If the exemption is denied the student will not be able to participate in clinical activities therefore unable to meet all program requirements.

Personal and Family Health History **Name _____**

The following two pages are to be completed by students prior to the physical exam.

Last name _____ First name_____ Middle initial_____
Date of Birth _____ Social Security # (last 4 digits) _____
Gender _____
Address _____
Preferred Phone _____
Emergency Contact and Phone_____
…….

Are you allergic to any medications? If so, what medications, and what was your reaction?

_____
_____
_____

Check any illness or medical conditions that you have had:

___ high blood pressure
___ rheumatic fever
___ heart disease
___ asthma
___ other lung disorder
___cancer
___ malaria
___ thyroid disorder
___ diabetes
___ allergies
___ arthritis
___ frequent headaches
___ severe head injury
___ autoimmune disorder
___ disabling depression
___ anxiety
___ gastrointestinal disorder
___ hepatitis
___ hernia
___ fatigue
___ anemia
___ vision or eye disorder
___ recurrent back pain
___ neck or back injury
___ kidney infection
___ hearing loss
___ sexually transmitted infection
___ blood transfusion

Provide details about any items checked. Attach an additional sheet if necessary.

_____
_____
_____

Do you smoke? ____ How many cigarettes/day? ____ Drink alcohol? _____ How many drinks/wk? ____

List all medications you take regularly. _____

_____
_____
_____
_____
_____
_____

Has any person related to you by blood had any illness or condition below? If so, check the condition and state the relationship of the family member to you.

___ high blood pressure _____
___ stroke _____
___ heart disease _____
___ blood disorder _____
___ high cholesterol _____
___ diabetes _____
___ glaucoma _____
___ cancer _____
___ substance abuse _____
___ psychiatric illness _____

Do you have any conditions that limit your physical activity?

Have you ever been hospitalized? Specify when and why.

Have you received treatment for a psychiatric, emotional, or behavioral disorder?

Do you have any vision problems not corrected with glasses or contact lenses or any hearing impairment?

Have you seen a physician in the past six months for anything other than routine well visits?

Have you had any serious injuries or illnesses not already noted?

Statement: I have personally supplied the above information and attest that it is accurate and true to the best of my knowledge.

Signature of student _____ Date _____

Printed name of student _____

Immunization Record **Name** _____

The student should complete the Immunization Record prior to the exam and provide documentation of any prior immunizations, titers, or screening tests to support the previous immunizations. If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

Required Immunizations

	Date	Date	Date	Date
DTP or Td (initial series)	___/___/___	___/___/___	___/___/___	___/___/___
Td or Tdap Booster (most recent)	___/___/___			
MMR (a after 1st birthday) or titer	___/___/___	___/___/___		
Varicella (2) or titer	___/___/___	___/___/___		
Hepatitis B (initial series) titer required	___/___/___	___/___/___	___/___/___	
Hepatitis B Booster (if non-immune) titer required	___/___/___			
Hepatitis B (optional to complete series)	___/___/___	___/___/___		
Influenza (seasonal)	___/___/___	___/___/___	___/___/___	___/___/___

Titers (where indicated)

	Date	Result
Rubeola (measles)	___/___/___	
Mumps	___/___/___	
Rubella	___/___/___	
Varicella	___/___/___	
Hepatitis B titer 1(after original series)*	___/___/___	**mIU/mL***
Hepatitis B titer 2(after single booster)*	___/___/___	**mIU/mL***
Hepatitis B titer 3(after 2nd series of 3) OPTIONAL*	___/___/___	**mIU/mL***

*A quantitative hepatitis B titer result is required.

Tuberculosis screening (most recent) Either PPD or TB blood testing is acceptable for health occupation students.

	Date	Date (TST)	Interpretation
PPD Placed	___/___/___	___/___/___	**N/A**
PPD Read (pos or neg) Or	___/___/___	___/___/___	
QuantiFERON Gold or T-Spot (pos, neg, or indeterminate)	___/___/___		

Or

	Date	Result
Chest X-ray (pos or neg)	___/___/___	
Record of TB screening (attach form and indicate low risk or high risk)	___/___/___	

If new immunizations, blood tests, or screening tests are done during this physical exam visit, the health care provider must document and initial those and sign the immunization summary.

_____ _____

Signature of physician, nurse practitioner, or physician's assistant **Date**

_____

Print Name of Health Care Provider

Physical Examination **Name _____**

Height _____ **Weight _____** **TPR _____/_____/_____** **BP _____/_____**

	Normal	Abnormal	Descriptions or Comments
Head, ears, nose, throat			
Eyes			
Respiratory system			
Cardiovascular system			
Gastrointestinal system			
Abdomen			
Genitourinary system			
Musculoskeletal system			
Endocrine system			
Neurological system			
Skin			
Mental health status			

Is the student under treatment for any medical condition? If yes, provide brief details of the disorder and treatment.

Are there currently any limits on the student's physical activity? How long will these limits apply?

Examiner's Statement: Based on my assessment of this student's physical and mental health, at this time s/he appears to be able to participate in the activities of a health profession in a clinical setting. Yes_____ No _____

Comments:

_____
_____
_____
_____
_____

_____ _____
Signature of physician, nurse practitioner, or physician's assistant **Date**

_____ _____
Print Name of Health Care Provider **Area Code and Phone**

_____
Office Address **City** **State** **Zip Code**

CRIMINAL DISCLOSURE FORM

I,_____ , have been made aware and understand the ramifications of the following offenses, in regard to my enrollment and progression in a health care provider program as it relates to me:

1. felony and/or misdemeanor convictions(s),
2. guilty plea or nolo contendere to any crime which indicates that one is unfit or incompetent to practice as a health care provider or that one has deceived or defrauded the public, and/or
3. parole violation.

Before I can enroll or continue in courses with a clinical component, any crime of which I have been convicted must be disclosed to the clinical agencies and college, which support the clinical components of the courses(s). Clinical agencies have the right to refuse a clinical practicum for students in their facilities.

Therefore, I may be unable to successfully complete the program because clinical objectives cannot be met, and I will be dismissed from the program.

I agree to hold harmless, the clinical agencies and staff, and college and staff for any acts under the North Carolina Tort Claims Act, NC GS 143-291 et seq. and accept responsibility for all claims, loss, liability, demands, damages, or any other financial demands that may be alleged or realized.

_____ _____
Student Signature **Date**

_____ _____
Witness Signature **Date**

_____
Witness Print Name

_____ _____
Witness Signature **Date**

_____

Witness Print Name

Approval To Register Form

Student Name: _____ **Student ID: _____**

Reviewers Name: _____ **Date: _____**

Course Name	Grade	Date Taken	College Taken With

Required Pre-requisites:
-ENG 111 (or equivalent)
-ENG 112 (or equivalent)
-MAT 143 or higher (or equivalent)
-BIO 163 or combination of BIO165/166 (or equivalent)
-College level humanities or sociology or psychology course
-Exhibit computer literacy or completion of college-level computer course

Student approved to register. **_____YES** **_____NO**

_____ **_____**
Reviewer's Signature **Date**

_____
Reviewer's Title