Certified Clinical Medical Assistant Training Program

Mandatory Requirements

- Registration Form
- Application for Training
- High School Diploma/GED
- Reading & Math Assessment
- Background Check
- Physical Exam
- Immunization Records (Hep B, MMR, Varicella)
- PPD Test
- Flu Shot
- Covid-19 Vaccination and Booster (if applicable)
- Online HIPPA Course *cf.rcgc.edu/hipaa/assessment*

I understand that all the above documentation must be submitted to the Career & Technical Education Division for enrollment into the Certified Clinical Medical Assistant Training Program.

Student Name: _____

Student Signature: _____

Date: _____

RCSJ CTE Representative: _____

Signature: _____

Date: _____

CTE Registration Form

Please complete all sections

Date: _____

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

Email: Birth Date: Social Security #:

How did you hear about our programs?

- ☐ CTE Catalog
- ☐ Opportunity Magazine
- ☐ RCSJ Website
- ☐ Social Media
- ☐ Friend/Relative
- ☐ Newspaper Ad
- ☐ Other

Course#	Course Title	Dates	Cost
		Total:	

Please Note: With the submission of this form, you are registered for the course. Unless notified to the contrary, please report to your first scheduled class. ***If your program course is being funded through a grant and you do not complete the program, you will be liable for the entire cost of the program; Courses costing more than $500 require a 50% deposit to hold your seat.***

Refund/Withdrawal Policy: We are happy to offer a refund or apply payment to another class of your choice if you withdraw five business days prior to the start of a class. Balance due by first day of class. If you wish to withdraw from a course, please notify the Career and Technical Department in writing or in person immediately. Refunds will be made as follows:

100% refund prior to the first class meeting.
50% refund on first day of class.
No refund after the first day.

By signing here, I understand and agree to the above terms and conditions: _____

Mail Registration Form To:

Rowan College of South Jersey—Cumberland
Career and Technical Education
3322 College Drive
Vineland, NJ 08360

Rowan College of South Jersey—Gloucester
Career and Technical Education
1400 Tanyard Road
Sewell, NJ 08080v

CTE Allied Health Program Application

Section 1: Student Information

Full Name: _____ Maiden/Other Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____ SS#: _____

Phone: _____ Birth Date: _____

Do you have a High School Diploma or GED? ☐ Yes *(Please attach copy)* ☐ No

Section 2: Program Selection and Status

I am applying for admission to:

Section 3: Immunizations and Tests

Program:	Check	Dates
Certified Clinical Medical Assistant		
Certified Nursing Assistant		
Patient Care Technician		
Certified Phlebotomy Technician		
Medical Billing & Coding		
Pharmacy Technician		
Central Service Technician		
Medical Administrative Assistant		
Other:		

Only for: Certified Clinical Medical Assistant, Certified Patient Care Technician, Phlebotomy Technician, Certified Central Service Technician and Pharmacy Technician. Please attach a copy of your physical and immunizations as necessary.

Vaccine	Dose-Date
Hepatitis B	1.
	2.
	3.
PPD Test Results (mm)	Date*:
MMR vaccination/Titer	Date:
Varicella vaccination/Titer	Date:
Flu Vaccine	Date: **Verification Required**

*Tuberculin test cannot be older than one year.

C.N.A Immunizations and Tests — ***See C.N.A Requirements Packet***

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Physician's Signature & Date: _____

Section 4: Acknowledgments

Externship (Only for Certified Clinical Medical Assistant, Certified Phlebotomy Technician, Certified Patient Care Technician and Central Service Technician — Initial after each.):

- **I understand** that if my program requires an externship, I will be required to complete all required hours before I will be considered a "graduate" of the program. _____
- **I understand** that my externship site could be withwin up to 30 miles of the school. _____
- **I understand** that most externship sites only offer externship during weekday hours and may not have the availability to provide evening or weekend hours. _____
- **I understand** that if I decline an externship site, the college's obligation regarding externship has been met and I will have to find my own externship placement._____
- **I understand** that if I am dismissed from an externship site, I will meet with the Director of Career and Technical Education and must find my own externship placement. _____
- **I understand** that if I don't have a minimum of a "C" average or an 85% attendance record that I may not be eligible for externship placement. _____
- If I am not in good financial standing with the College, I will not be able to be placed on externship until paid in full. _____
- **I understand** that I will need to submit proof of being fully vaccinated against COVID-19 in compliance with externship site requirements._____

Certification Exams and Licensures (*Initial after each):*

- **I understand** that Rowan College of South Jersey makes no guarantee that students who complete training will pass the national certification exam and licensures *(if available)*._____
- **I understand** that Rowan College of South Jersey will only pay for my first attempt at the national certification exam and licensure. All retests are my responsibility. _____

Release of information

I, (print name) _____ , authorize Rowan College of South Jersey Career and Technical Education to conduct a search and to release all my records pertaining to my criminal history, which includes my name, social security number, date of birth, address, and student ID number to the authorized background check agency of their choice.

I understand that the use of my records is limited to any audit and the evaluation of continuing education programs, to any potential externship preceptors, and in connection with the enforcement of federal and/or-state laws.

My signature is an acknowledgment that I have read and voluntarily consent to the release of the above-mentioned information.

Student Signature: _____

Refund Policy

There will be a 100% refund for withdrawals before the first day of class. A 50% refund for withdrawals on the first day of class. No refunds after the first day of class.

I understand and agree to the above terms and conditions:

Student Signature: _____ Date: _____

CTE Acceptance of terms of Drug and Alcohol Use Policy

It is strictly forbidden to be under the influence of alcohol, illegal narcotics, chemicals, psychedelic drugs or other controlled substances by an individual engaged in college related activities.

It is expected that students will come to class, laboratory and externship in a condition fit for the competent and safe performance of their duties and that such fit condition will be maintained throughout the scheduled time. The objectives of this policy are to identify the impaired students, maintain an environment that allows students to enjoy the full benefits of their learning experience and ensure safe, competent client care.

Faculty are accountable for ensuring that students are in fit condition to participate in program related activities and for taking prompt, appropriate and decisive action whenever a student seems to be impaired. Students who arrive in the classroom, lab, externship location or other assigned area and are considered by their instructor to be impaired may expect to:

- Have their behavior witnessed and documented
- Be questioned in private as to the nature of their problem
- Be asked to undergo a medical evaluation (which includes blood alcohol level and/or urine testing) in an Emergency Room or laboratory facility and have their behavior witnessed by another healthcare professional
- Meet with the Director of Career and Technical Education
- Be referred for counseling
- Be dismissed from their program of study
- Be ineligible for readmission

When a student is in possession of or using alcoholic beverages or illegal or unprescribed controlled chemicals on college or externship properties, the student may be assigned a grade of “F” and be dismissed from their academic program. I have read and understand the Career and Technical Education’s Drug and Alcohol Use Policy.

_____ _____

Signature: *Date:*

Physical Examination Form for Certified Clinical Medical Assistant

To be completed by a Health Care Provider

Instructions: This Physical Examination Form is to verify the health status of this student who has been accepted into the Central Service Technician program at Rowan College of South Jersey upon verification of adequate health status.

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ E-mail Address: _____

Home Phone: _____ Cell Phone: _____

Date of Exam: _____

HT: _____ WT: _____ BP: _____ P: _____ Urine Dip: _____ Hb: _____

NL	ABNL Findings
☐	☐ Head/Neck _____
☐	☐ Eyes _____
☐	☐ ENT _____
☐	☐ Lungs _____
☐	☐ Cardiac _____
☐	☐ Breast _____
☐	☐ Abdomen _____
☐	☐ GU (as indicated) _____
☐	☐ Rectal (as indicated) _____
☐	☐ Back Strength/Extremities _____

Yes	No
☐	☐ Ability to lift and carry up to 50 lbs. _____
☐	☐ Ability to exert up to 100 lb. Force or push/pull _____
☐	☐ Ability to bend/stand/squat/crawl _____

NL	ABNL
☐	☐ Neuro _____
☐	☐ Reflexes _____
☐	☐ Lymph's _____
☐	☐ Skin _____

Remarks: _____

The student is sufficiently free of disease and able to perform duties. He/she does not have any health condition that would create hazard for him/herself, fellow students, facility employees, residents, or visitors.

MD signature: _____ Date: _____

Rowan College SOUTH JERSEY

Tuberculin Skin Test Requirements	Date/Results	Date/Results
2 Step TB Skin Test (PPD) 2 TB Skin Test: a minimum of 1 week or a max of 3 weeks apart	1st Step Date: _____ Results: _____ * If positive PPD result, see Chest Xray & Letter	2nd Step Date: _____ Results: _____
Chest Xray & Letter from Physician * Only require if positive TB Skin Test * Negative Chest Xray (within last 5 years) ** A letter from your physician stating you are free of any symptoms of TB*	Date: _____ Results: _____ INH Treatment- 9 Mos. Date Began: Date Ended:	

TB Symptoms Review:

1. Are you currently exhibiting any of the following symptoms of tuberculosis?

Hoarseness/Cough lasting longer than 3 weeks	_____ yes	_____ no
Coughing up Blood	_____ yes	_____ no
Fever	_____ yes	_____ no
Weight Loss	_____ yes	_____ no
Night Sweats	_____ yes	_____ no
Excessive Fatigue	_____ yes	_____ no

Have you had any of the above TB symptoms within the last 12 months? _____

If yes, explain _____

_____

2. Have you ever been told by a doctor or other health care provider that you had active TB? _____ Yes or No

3. Have you ever been told by a doctor or health care provider that your immune system is not working right or that you cannot fight infection? _____ Yes or No

4. Have you had pneumonia in the past year? _____ Yes or No

5. Have you ever lived with or had close contact with someone who has/had active TB with symptoms listed above? _____ Yes or No.

If yes, list symptoms _____

_____

6. Is any person living in your household exhibiting any symptoms of TB that are listed above? _____ Yes or No

If yes, list symptoms _____

_____

7. Have you ever been told that you have an abnormal chest x-ray or had a chest x-ray to rule out TB? If yes, where was the chest x-ray done; physician name and number: _____

_____

_____

Continues on next page

8. Have you ever received medication for active tuberculosis disease or preventative treatment for TB injections?
If yes, list medication, date started, and date completed: _____

_____

_____

9. Have you ever worked where patients with active tuberculosis are receiving care? _____

10. Have you ever worked, volunteered, or lived in any situation such as jail, group home, or homeless shelter? _____

11. Have you ever traveled outside the United States?_____If yes, where _____

12. Were you born in the United States?_____If no, where were you born? _____

Student signature: _____ Date: _____