SoutheastHEALTH
College of Nursing & Health Sciences

APPLICATION CHECKLIST

PATIENT CARE TECHNICIAN

Before applying, please check the eligibility requirements for these courses. Applicants who do not meet the eligibility requirements will not be admitted.

Please review the lists below to ensure that all required documents are submitted. The items in the top section are items to submit with the application which can be mailed or dropped off during regular business hours. The items in the bottom section should be mailed (not faxed) by the individuals or organizations submitting the documents and should be mailed directly to:

Admissions Office
2001 William Street
Cape Girardeau, MO 63703

Applicant should submit with application:

- ☐ Fully completed Application Form
- ☐ $45 Application Fee (non-refundable after 3 business days)
- ☐ Copy of valid Photo Identification (driver's license, state/federal ID, US passport)
- ☐ Medical History Form
- ☐ Immunization Records or titers (may be included with high school transcripts)
- ☐ Gainful Employment Acknowledgement form (included in this packet)
- ☐ Background Check Form (only complete the highlighted sections)
  (The fees for the background checks are included in the application fee.)

Individuals or organizations sending these items should mail them directly to College:

- ☐ Official High School or high school equivalency transcript (If your high school equivalency exam scores may be obtained online, please provide the website on the appropriate section of the application.)

All items listed above must be received before the application will be reviewed.
It is the applicant's responsibility to make sure items are received.

A week or two after submitting your application you will receive an email with instructions on how to access our database to view the missing checklist items and the current status of your application.

Southeast Mo Hospital College of Nursing and Health Sciences

Patient Care Technician (PCT) Application

Please print clearly.

_____

First Middle Last Maiden/Previous

_____ mm/dd/yyyy _____ _____ _____

Birthdate: Home phone Cell phone Work phone

Mailing address:

_____

Street City ST Zip

_____ _____

County Email address

US Citizen or permanent resident? _____Yes _____No

Name of High School Attended: _____

If high school equivalency by exam, please indicate instead of name of high school and provide website for scores if applicable

Emergency Contact:

Name: _____

First Last

Address: _____

Street City ST Zip

Phone: Home _____Cell _____ Work _____

Check the courses you are interested in applying for:

__**X**__ **8 week Patient Care Training**
_____ **2 week Arrhythmia Training**
_____ **2 week Phlebotomy Training**

Are you currently an employee of SoutheastHEALTH ____Yes ___ No

Have you ever been suspended or dismissed from any school/college? Yes No

Have you ever been placed on academic or disciplinary probation? Yes No

Have you ever been convicted of a criminal offense? Yes No

If you answered "Yes" to any of the above questions, please explain the reason or nature of the offense. Include all offenses even if you may have been told the offense would not appear on your record.

_____

_____

I affirm that all information supplied is complete and accurate. I understand that any misrepresentation or change of facts could be cause for refusal of admission, cancellation of admission, or suspension from the College.

_____ _____

Legal signature Date

Gainful employment Information will be available after graduation of first class.

SoutheastHEALTH
College of Nursing & Health Sciences

GAINFUL EMPLOYMENT ACKNOWLEDGEMENT

Patient Care Technician

I understand that Gainful Employment information is not yet available for this new program.

Printed name: _____

Signature: _____

Date signed: _____

SoutheastHEALTH
College of Nursing & Health Sciences

Program: _____

Medical History Form

This information is confidential and will be used as an aid in providing necessary health care while you are a student. Please return this form with your application. Health information is only reviewed after the admission committee recommends an applicant be admitted.

_____
First Name | Middle Name | Last/Family Name | Previous Names (if applicable)

_____ _____ Circle one: Male Female
Social Security Number | Date of Birth (mm/dd/yyyy)

_____
Address | City | State | Zip | County

_____ _____ _____ _____
Home Phone | Cell Phone | Work Phone | Email address

Emergency Contact: _____
Full Name | Relationship

_____
Address | City | State | Zip | County

_____ _____ _____
Home Phone | Cell Phone | Work Phone

Family Physician: _____
Full Name | Phone Number

_____
Address | City | State | Zip | County

Insurance: _____
Medical Insurance Company | Policy Number | Group Number

The College strongly urges every student to subscribe to an insurance plan which provides comprehensive medical, surgical treatment, and accidental care.

Immunization History: The Missouri Division of Health is requesting we have a documented record of a student's immunizations. Please include a copy of your immunization records: from your baby book, public health record, high school records, or a copy of your doctor's records. These include measles, mumps, and rubella (MMR), chicken pox, hepatitis B, and tdap (tetanus/pertussis).

Personal Health History: Please indicate which diseases or problems you currently have or have had in the past and explain "yes" answers on the lines below.

Childhood Diseases			**Chronic or Continuing Problems**					
Measles (Regular, Hard, Red)	Yes	No	Anemia	Yes	No	Heart Disease	Yes	No
Rubella (3 day)	Yes	No	Anxiety	Yes	No	Congenital Heart Problems	Yes	No
Chicken Pox	Yes	No	Arthritis	Yes	No	Hemophilia	Yes	No
Mumps	Yes	No	Asthma	Yes	No	Hepatitis B	Yes	No
			Chronic Back Problem	Yes	No	Hepatitis C	Yes	No
Acute Diseases			Cancer	Yes	No	High Blood Pressure	Yes	No
Hepatitis A	Yes	No	Chronic Cough	Yes	No	Frequent Indigestion	Yes	No
Infectious MoNonucleosis	Yes	No	Colitis/Colon Problems	Yes	No	Kidney/Bladder Problems	Yes	No
Pleurisy	Yes	No	Convulsions or Seizures	Yes	No	Malaria	Yes	No
Pneumonia	Yes	No	Depression	Yes	No	Mental Disorders	Yes	No
Poliomyelitis	Yes	No	Diabetes	Yes	No	Sinusitis	Yes	No
Repeated bouts of Strep Throat	Yes	No	Diminished Hearing	Yes	No	Tuberculosis	Yes	No
Other (list below)	Yes	No	Dizziness/Fainting	Yes	No	Drug Allergies	Yes	No
			Excessive Drinking or Drug Use	Yes	No	Other Allergies	Yes	No
			Headaches	Yes	No	Other (explain below)	Yes	No

Please explain all "Yes" answers, any surgeries, allergies, and any serious injuries (broken bones, etc.):

_____

_____

Current Medications: _____

I do hereby consent, authorize, and request health services personnel and any physician or medical representative to whom referral is made to conduct treatment which may deem advisable in the event should I require medical care while a student at Southeast Missouri Hospital College of Nursing and Health Sciences.

_____ _____
Legal Signature | Date

Exhibit B

AUTHORIZATION FORM – *www.backgroundcheckadvantage.com* 4/6/2016

Background Check ADVANTAGE®

Southeast HEALTH College of Nursing & Health Sciences

Southeast Missouri Hospital
College of Nursing & Health Sciences
2001 William St., Cape Girardeau, MO 63703
Phone: 573/334-6825 Fax: 573/339-7805

First Name	Middle Name	Last Name

Alias/Maiden Name(s)	Will Employee's Salary Exceed $75,000?
	☐ No ☐ Yes

Social Security Number	Date of Birth	Race	Gender
			☐ Male ☐ Female

Mailing Address (NO P.O. Boxes)	City	State	Zip

As part of the ☐ employment ☐ volunteer ☑ student ☐ credentialing process, I consent to the release of my criminal background records and motor vehicle driving records or any search listed below by any and all states or agencies holding such records. I also agree to an investigation and the obtaining of a consumer report solely for ☐ employment ☐ volunteer ☑ student ☐ credentialing purposes. By signing this consent, I acknowledge I have received in writing a Disclosure Regarding Procurement of a Consumer Report. I understand that the Company named above may use this consent on multiple occasions to request such consumer reports. This consent will remain effective until I have affirmatively revoked it.

_____ **DATE:** _____ /_____ /_____

Signature of Applicant

BACKGROUND SEARCHES

☐**OIG** (Medicare/Medicaid Fraud & Abuse) ☐**GSA** (Federal Procurement Fraud) ☐****FCSR**

☐**SSN Plus** (Address & Alias Name are included) ☐**Address Verification** ☐**Alias Name Search**

☐**Government Watch List** (includes DOC Entity List & Denied Persons List, DOT Specially Designated Nationals & Blocked Persons List, DOS Proliferation List & more)

☐**Wants & Warrants** (Nationwide - extraditable only) ☐**OFAC** (Specially Designated Nationals and Blocked Persons List)

Child Abuse/Neglect – ☐ **IL**** ☐ **IA**** ☐ **IN**** ☐ **KS**** ☒ **MO*** ☐ **NE**** ☐ **TN**

☐***MO Mental Health Employee Disqualification Registry** ☐**MO EDL** (Employee Disqualification List)

☐**FEDERAL COURTS - Criminal State 1:** _____ **2:** _____ **SEX OFFENDER** ☐**Nationwide or** ☐**State 1:** _____

☐**DRIVING RECORD State** _____ **DL#** _____

☐**PROFESSIONAL LICENSE** ☐ **National or** ☐ **State** _____

Type: _____ **License Number:** _____

☐**EDUCATION School Name** (include campus)**:** _____

City/State: _____ /_____ **Major:** _____ **Graduation Date:** ____ /_____

Degree Type: _____ **(BSN, B.A., etc.) Name While Attending:** _____

If additional Verifications are needed, refer to application during data entry or document on another Background Check Request Form.

☐**EMPLOYMENT Company:** _____ **City/State:** _____ /_____

Phone: _____ /_____-_____ **Manager:** _____ **Start Date:** ___ /_____ **End Date:** ___ /_____

Title: _____ **Starting Wage:$**_____ **Ending Wage:$**_____

Duties: _____

Reason for Leaving: _____

If additional Verifications are needed, refer to application during data entry or document on another Background Check Request Form.

LIST CITY/COUNTY CRIMINAL SEARCHES NEEDED

States with county by county access only: CA, LA, MA, WV and WY

County 1:_____**State:** _____ **County 2:**_____**State:** _____ **County 3:**_____**State:** _____

STATEWIDE CRIMINAL - A Statewide/State Repository houses records from all jurisdictions throughout the State

☐ AL*	☐ AK	☐ AZ	☐ AR*	☐ CO	☐ CT*	☐ DE	☐ DC*	☐ FL	☐ GA*
☐ HI	☐ ID**	☐ IN	☐ IA*	☐ KS	☐ KY	☐ ME	☐ MD	☐ MI	☐ MN
☐ MO	☐ MS*	☐ MT	☐ NE	☐ NV*	☐ NH**	☐ NJ	☐ NM*	☐ NY*	☐ NC
☐ ND	☐ OH*	☐ OK	☐ OR*	☐ PA	☐ RI*	☐ SC	☐ SD	☐ TN	☐ TX
☐ UT*	☐ VA*	☐ VT*	☐ WA	☐ WI					

Note: Nevada & Ohio are **Felony** Only

☐ Illinois Healthcare-compliance with IL Healthcare Worker Background Check Act *(IL Police Full-State Repository Criminal)*

MO-includes MO Sex Offender results at no additional cost *(MO State Highway Patrol Full-State Repository Criminal search)*

***Required Form(s) & **Required Special Form(s) must be ATTACHED when ordering or faxed to 573-893-7669**