NA115 – Phlebotomy Technician Clinical Clearance Instructions

The following documents must be completed and submitted to your instructor *no later than the 4th week of class*. These are required to complete clinical rotations. Please note the estimated cost for the physical, immunizations, and background check is in addition to tuition.

1. Health Record Form
2. Physician's documented immunization record
   (Can be completed by nurse practitioner in Student Health Clinic on campus. Cost for physical is $10; TB test is $20)
3. Copy of Driver's License
4. Copy of Health Insurance Card
5. Background check with fingerprinting (Background form attached; Cost $73.30)
6. Current CPR Certification *American Heart Association BLS for healthcare providers*
   (For students needing to renew or become certified, this will be offered in August on campus as a one-day class. Information on dates/times to be announced)

Items Needed for Clinical Rotations

- Solid colored Scrubs (no prints)
- Name Tag (provided by NMSU Carlsbad)
- Reliable transportation

CARLSBAD

NMSU Carlsbad Phlebotomy Technician Student Health Record

DIRECTIONS: Please print in ink *(blue or black)* or type before going for examination. Be sure to answer all questions completely. Information will not be released to unauthorized persons without your written consent. If requesting accommodations, you must provide appropriate medical, psychological, and/or psychiatric documentation to support this request.

Name _____
Last First Middle Initial

Home Address _____
(Street) (City) (State) (Zip)

Social Security Number _____ Birth Date _____

Telephone _____
(Home) (Cell)

SECTION II: PHYSICAL EXAMINATION (To be completed by the physician, physician assistant, or nurse practitioner)

Height _____ Weight _____ Blood pressure _____

Corrected Vision: Right 20/ _____ Left 20/_____

Hearing: Right: _____Normal _____Impaired Left: _____Normal _____Impaired

A. Does the student have any abnormalities in the following systems? (Give dates, description of abnormality and treatment of ALL findings.)

System	Yes	No	System	Yes	No
Eyes			Respiratory		
Ears, Nose, Throat			Genitourinary		
Cardiovascular (including murmurs)			Skin		
Neurological			Immunological		
Color Blindness			FIT Test (N-95 Respirator)		

B. If you have answered "yes" to any item in "**A**" above, please complete the following: (Record additional information on back of this page).

Date	Diagnosis	Treatment

Please list any other medical conditions not addressed above: _____

_____

Please list all medications that you are currently taking: _____

SECTION III: IMMUNIZATIONS **Student Name: _____**

You are required to provide the Phlebotomy Instructor with proof of required immunization and PPD screening. Please provide copies of immunization through record of titer, immunization, or physician's documentation of illness. **Provide this form to your Physician or Health Care provider to complete and sign if you do not have a shot record.**

Measles, Mumps, Rubella

Documentation of two immunizations given after 12 months of age:

____ /____ /____ ____ /____ /_____

Month Day Year Month Day Year

OR

Antibody Titer IgG proving immunity (Copy of lab report required):

____ /____ /___ ____ /____ /____

Month Day Year Month Day Year

DPT

Documentation of two immunizations given after 12 months of age:

____ /____ /___ ____ /____ /____

Month Day Year Month Day Year

Tdap

Tdap (Adacel or Boostrix) _____ / _____ / _____ (must be within 10 years)

Month Day Year

Varicella

Documentation of two immunizations given after 12 months of age:

_____ /_____ /____ _____ /_____ /_____

Month Day Year Month Day Year

OR

Varicella antibody titer IgG proving immunity (copy of lab report required)

_____ /_____ /_____ _____ /____ /_____

Month Day Year Month Day Year

If needed, date of booster:

***Tuberculosis Screening* (Mantoux ONLY) within 3 months prior to admission**

Date Placed: _____ / _____ / _____ 2. Date Read: _____ / _____ / _____

Month Day Year Month Day Year

PPD Results: ____ Non-induration or non-reactive ____Indurated or reactive _____mm

_____ History of positive PPD (Note: If indurated/reactive or history of positive PPD, must attach copy of Chest x-ray report taken within 3 months of matriculation.)

Hepatitis B Vaccine

Series of three Hepatitis B Vaccine

1st injection _____ / _____ / _____ 2nd injection ____ / _____ / _____ 3rd injection _____ / _____ / _____

Month Day Year Month Day Year Month Day Year

OR

Hepatitis B Surface Antibody titer IgG quantitative + lab copy _____ / _____ / _____

Month Day Year

Second series (if needed)

1st injection _____ / _____ / _____ 2nd injection ____ / _____ / _____ 3rd injection _____ / _____ / _____

Month Day Year Month Day Year Month Day Year

Polio (Circle OPV or IPV)

Primary series completed _____ / _____ / _____
Month Day Year

OR

Series of three Polio Vaccine

1st injection _____ / _____ / _____ 2nd injection ____ / _____ / _____ 3rd injection _____ / _____ / _____
Month Day Year Month Day Year Month Day Year

SECTION IV: ESSENTIAL FUNCTIONS REQUIRED FOR THE PHLEBOTOMY TECHNICIAN COURSE

The following standards are considered essential criteria for participation in the Phlebotomy Technician Course. Students must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Phlebotomy Technician course. For acceptance into the Phlebotomy Technician Course, all applicants with or without accommodations must:

- Possess sufficient visual acuity to independently read and interpret the writing of all sizes.
- Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs.
- Possess sufficient gross and fine motor skills to manipulate equipment and instrumentation, and perform other skills required in meeting the needs of the phlebotomy patient.

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Print Name of Physician, Physician Assistant, or Nurse Practitioner ***Date***

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner ***Date***

Clinic (if applicable): _____

Address: _____

Phone: _____

****Students are advised to maintain a copy of this form and all applicable immunization records for future use.***

Titers will be required only if immunization documentation is not available to show immunity.

If you are required a titer, please have physician sign this lab request form to present to the laboratory to ensure accurate tests are obtained

LAB ORDERS (Please select)**:**

- ☐ Hepatitis B Surface Antibody QUANTITATIVE*
- ☐ Rubella Antibody, IgG
- ☐ Rubeola (Measles) Antibody, IgG
- ☐ Mumps Antibody, IgG
- ☐ Varicella Antibody, IgG

*__Hepatitis B Surface Antibody Quantitative__

(**Note:** DO NOT draw if you are unable to provide a numerical quantitative result. A qualitative exam is NOT acceptable)

_____ _____

Physician/Provider Signature Date

NMSU Carlsbad Phlebotomy Technician Background Check Form

Student Information – Please Print Clearly						
Last Name:	***Maiden:***	***First Name:***	***Middle Name:***	***Alias/Other Names you have gone by:***		
Physical Address:		***City:***		***State:***	***Zip Code:***	***County***
Date of Birth:			***Aggie ID #:***			
Primary Phone #:			***NMSU Email:***			
Secondary Phone#:			***Other Email:***			

Person To Notify In Case of Emergency:		
Full Name:	***Relationship:***	
Address – Number & Street:		
City:	***State:***	***Zip Code:***
Primary Phone:	***Secondary Phone:***	

Information for Caregiver Criminal History Screening & Electronic Fingerprint Request

(*Criminal Background checks will be completed after enrolled and courses started. Do NOT complete prior to starting the course***)**

Social Security #:	***Date of Birth:***	***Heritage (circle one)*** Asian Black American Indian Caucasian Hispanic Other:
Gender: Male Female	***Natural Eye Color:*** Black Blue Brown Gray Green Hazel Other:	***Natural Hair Color (circle one)*** Bald Black Blonde Brown Gray Red Sandy White Other:
Height:	***Weight (lbs):***	***US Citizen (circle one):*** Yes No
Place of Birth (City, State, Country):		

List the states that you have lived in the last 7 years, include the dates resided. If you need more room use back of form.

State:	***Dates From:***	***Dates To:***	***State:***	***Dates From:***	***Dates To:***	***State:***	***Dates From:***	***Dates To:***

Driver's License Information		
State Issued In:	***License Number:***	***Expiration Date:***

Instructions for Background Check Process:

1. Fill out NMSU Carlsbad Phlebotomy Technician Background Check Form **after the course starts**. **Do not complete prior to the course start date.**
2. Turn into Erin Kuh (Office 462) in the Allied Health/Nursing Building
3. Allied Health will notify you when to pick up your paperwork.
4. Take paperwork to CARC at 902 W. Cherry Ln. with a money order payable to 3M Cogent for the amount of $73.30 to complete the background check/fingerprinting process. CARC (575) 887-1570