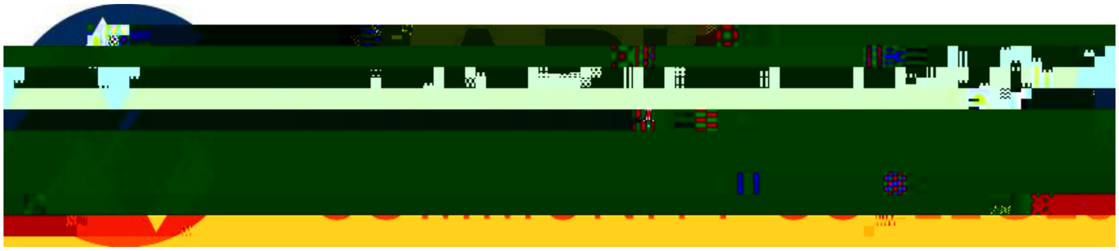

Mycobacterium tuberculosis

(Excerpts from OSHA Blood borne Pathogens Section 1910.1030)

Religious Practice or Belief:

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT ALLIED HEALTH PROGRAMS

this Program and agree to abide by them. I have carefully read this Voluntary Assumption of Risk and Release of

I (print name)____give permission for the Allied Health faculty and/or Allied Health Director/Chair of the Program in which I am enrolled to share personal information about me including name, , date of birth and verification that the Program has evidence that I have met all the health and safety requirements of the Allied Health Program. This information will be provided to clinical agencies where I am assigned so that I may complete mandated pre-

These Policies prescribe standards of conduct for students enrolled in MCCCD Allied Health Programs. The standards are in addition to those prescribed for students under Maricopa Community Colleges policies and administrative regulations. Violation of any such standard may serve as grounds for program dismissal, suspension, or other discipline.

Every student is expected to know and comply with all current policies, rules, and regulations as printed in the college catalog, class schedule, college student handbook, and specific MCCCD Allied Health Program student handbook. Copies are available at many sites throughout the college.

I have received a copy of the Allied Health Programs Policies. I understand this handbook contains information about the guidelines and procedu

In order for students to be admitted to or maintain enrollment in good standing in Maricopa County Community Colleg important as it demonstrates character. Lack of honesty will be the basis for denial of admission or removal from a Program if information that should have been disclosed but was not would have resulted in denial of admission. Failure to disclose other types of information constitutes a violation of the Student Code of Conduct and may be subject to sanctions under that Code. Students have a duty to update the information requested on the [background check vendor] data collection form promptly during enrollment in a Program. The data collection form may ask for the following information but the form may change from time to time:

[illegible]

ω Homeland Security Search

8. By virtue of the MCCCD supplemental background check, I understand that I will be disqualified for admission or continued enrollment in a Program based on my criminal offenses, the inability to verify my Social Security number, or my being listed in an exclusionary database of a Federal Agency. The criminal offenses for disqualification may include but are not limited to any or all of the following:
   - Social Security Search ς Social Security number does not belong to applicant
   - Any inclusion on any registered sex offender database
   - Any inclusion on any of the Federal exclusion lists or Homeland Security watch list
   - Any conviction of Felony no matter what the age of the conviction
   - Any warrant any state
   - Any misdemeanor conviction for any of the following regardless of the age of the crime
     - violent crimes
     - sex crime of any kind including non consensual sexual crimes and sexual assault
     - murder, attempted murder
     - abduction
     - assault
     - robbery
     - arson
     - extortion
     - burglary
     - pandering
     - any crime against minors, children, vulnerable adults including abuse, neglect, exploitation

10. I understand that if a clinical agency to which I have been assigned does not accept me based on my criminal background check, it may result in my inability to complete the Program. I also understand that MCCCD may, within its discretion, disclose to a clinical agency that I have been rejected by another clinical agency. I further understand that MCCCD has no obligation to place me when the reason for lack of placement is my criminal background check. Since clinical agency assignments are critical requirements for completion of the Program, I acknowledge that my inability to complete required clinical experience due to my criminal background check will result in removal from the Program.
11. I understand the Programs reserve the authority to determine my eligibility to be admitted to the Program or to continue in the Program and admission requirements or background check requirements can change without notice.
12. I understand that I have a duty to immediately report to the Program Director any arrests, convictions, placement on exclusion databases, suspension, removal of my DPS Fingerprint Clearance Card or removal or discipline imposed on any professional license or certificate at any time during my enrollment in a Program.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Printed Name	Desired Health Care Program

______________________________ :____________

Use this worksheet as a guide to ensure that you have documentation of each requirement. upload this document into or myClinicalExchange. Only supporting documents (lab results, immunization records, signed healthcare provider form, etc.) for each requirement should be uploaded.

Additional information regarding acceptable documentation for each requirement can be found on the website. MCCCD requires all students to meet the placement requirements as set up by our program s most stringent clinical partner. We do this for ease of random placement.

5. Documentation of a negative chest X-ray (x-ray report) or negative QuantiFERON result and completed Tuberculosis Screening Questionnaire (available in).

Date: ____________

To meet requirement:

1. Positive HbsAb titer Date: ______________ Result: ____________

1. Proof of 2 Hepatitis B vaccinations

Hepatitis B vaccine/dates: #1______________#2____________

OR

2.

3. Proof of 3 Hepatitis B vaccinations
Hepatitis B vaccine/dates: #1______________#2_____________ #3____________

4. Hepatitis B declination- students who choose to decline Hepatitis B vaccine series must submit a HBV Vaccination Declination form.

To meet requirement:

Documentation of current annual flu vaccine Date: ________________

It is essential that allied health students be able

NURSING AND ALLIED HEALTH PROGRAMS

Student Name	Date
Program	Student ID

I decline the seasonal influenza vaccine due to religious beliefs and/or medical contraindications as indicated by my initials below.

I understand and agree that

By