Phlebotomy Technician Checklist:

_____ 18 or Older
_____ Phlebotomy Technician Application
_____ Release and Hold Harmless Agreement/Waiver of Liability Form
_____ Official High School/GED Transcript
_____ Background Check
_____ Immunization Records
_____ MMR (2 doses), Hepatitis B (3 doses) and Tetanus within the last 10 years
_____ Proof of Current Tuberculosis (TB) Skin Test
_____ Secured Funding (Tuition $2,400)
_____ BLS First aid/CPR Card
_____ Drug Screen
_____ History and Physical

***All requirements must be met and all supporting documentation must be submitted 3 weeks prior to the start date of class. ***

Funding Options: Workforce Commission Office, Sallie Mae, and out of pocket.

Please fax the program application and all supporting documentation to 337-521-6685.

If you have any questions, feel free to contact: The Workforce Training Coordinator at 337-521-6687.
Phlebotomy Technician Application

Thank you for your interest in our Phlebotomy Technician Program here at SLCC - Opelousas Campus. Classes are filled on a first come first served basis. Your immunizations, proof of Hepatitis B (3 doses), MMR (2 doses), and Tetanus within the last 10 years TB test results, hepatitis series, and BLS First aid/CPR must be up to date!

This Information Packet includes:
1. Background check Information.
2. Application to be filled out by student.
3. Release and Hold Harmless Agreement/Waiver of Liability Form
4. History and Physical

BACKGROUND RESEARCH SOLUTIONS
PO Box 3083 Slidell, LA 70459
Phone: 985-503-7911
Fax: 877-993-0661
https://BR-Solutions.net
apply2check@br-solutions.net

Admission Background Screening Instruction:

- Go to br-solutions.net
- Locate the School tab in the Menu Bar
- From the drop down select your respective school then program of study.
- Follow listed instructions, "The accuracy of the completed reports depends on the accuracy of the submitted information, so please verify all information before submission", click Continue to Next Step.
- Fill in Required Demographics and click Continue to Next Step
- Select Box. I consent to digital signatures and authorization, and I authorize this background check to be performed on me, then click Continue to Next Step - Review/Sign Forms.
- Click on Applicant Release, sign form with mouse on a computer/laptop, Finger/Stylus on a phone/tablet/touch pad laptop, save signature and click Continue to Next Step.
- Fill in Payment Information and Submit to process report
- Successful submissions will provide a six-digit ID#.
- Students will receive a notification that their report is complete, but no action is necessary on their part. The completed report will be emailed directly to program director.
Additional Information:

- Once the student has turned in the application, immunization records, proof of Hepatitis B (3 doses), MMR (2 doses), and Tetanus within the last 10 years, TB test results, a copy of BLS First Aid/CPR, and background check results everything will be processed.
- You will need to purchase black scrubs, tennis shoes with no mesh, a notebook, pens or pencils, and a highlighter. Once you are accepted into the program, you will receive an email with more information.
- Classes will be held during the day for 8 weeks Monday-Thursday, from 9:00am to 1:00pm. Clinical rotation is held weeks 9-10 (the length of the externship depends on the time it takes a Student to complete 75 venipunctures, with a minimum of 30 successful venipunctures sticks and 10 Capillary Sticks). **Students MUST be able to complete their externship!!!** ***Students have a one week drop period!!!***
- Tuition Includes: book, online material, and certification testing fee. Upon completion of the program students will receive a voucher to sit for the CPT exam.

Next class starts: ____________________________

For further information, you may contact: Kala Marks at kala.marks@solacc.edu, or call and leave a detailed voice message at either: 337-521-6687 or 337-521-9028. We look forward to assisting you in achieving your career goals.
Application for Phlebotomy Technician Program

Personal Information

Name: _____________________________________________

Social Security Number: _____________________________

DOB: ________________________________

Physical Address: _______________________________________

City, state, Zip: _______________________________________

Mailing Address (if different): ________________________________

City, state, Zip: _______________________________________

Home phone: __________________ Cell phone: __________________

Email Address: _______________________________________

Emergency Contact

Name: _____________________________________________

Relationship: _______________________________________

Phone Number: _______________________________________

SLCC cannot accept students who have been convicted/found guilty of drug charges, abusing, neglecting, or mistreating an individual. Other positive findings in the background check can make you ineligible for acceptance into the program as well.

My signature below indicates awareness of the above statement and my responsibility in paying for a TB skin test, background check, BLS First aid/CPR, hepatitis series, uniforms, tennis shoes, and school supplies.

_____________________________________________  ______________
Signature of Applicant  Date

Application received by: ___________________________  Date: __________________
SOUTH LOUISIANA COMMUNITY COLLEGE
HISTORY AND PHYSICAL EXAMINATION FORM
Program: Phlebotomy

To be completed by applicant: (front and back must be completed)

Name: ________________________________ Phone: __________________________
Address: ____________________________City/State/ZIP: _______________________
Age: ______ Date of birth: ___________ Height: ______________ Weight: ____________

Medical/Surgical History: Be specific!!

1. Previous Illnesses: (must complete reverse side also) ______________________________

2. Previous Surgeries: _____________________________________________________________

3. Present Illness/disorder: _______________________________________________________
   ________________________________________________________
   ________________________________________________________
   ________________________________________________________

4. Current Medications (include dosage and frequency): NOTE: a letter on your physician’s letterhead
   (not on a prescription pad) and signed by the physician (NOT STAMPED) is required for all
   prescription medication indicating the dosage and frequency of the medication. Physician must also
   indicate in the letter that the medication(s) will not impair your ability to function effectively and
   safely in a clinical setting. See Technical Performance Standards.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

5. Are you currently under the care of a physician or psychiatrist?
   ___ Yes ______ No If yes, please explain circumstances: Be specific!
   __________________________________________________________________________
   __________________________________________________________________________

   (Name of Physician: ____________________________ Please print legibly)

6. Do you have any disorder or disability that limits your cognitive (conscious) awareness or
   physical activity or that requires special accommodations either continuously or intermittently?
   _______ Yes _______ No If yes, please describe: ________________________________
   __________________________________________________________________________

Note: if you are pregnant please have the physician complete the appropriate
information on next page.
7. Please indicate if you currently have or have ever had any of the following. You must explain all YES answers and discuss them with the physician.

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
<th>Explain all YES answers here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual defects/problems</td>
<td></td>
<td></td>
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<tr>
<td>Color blindness</td>
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<tr>
<td>Hearing defects/problems</td>
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<tr>
<td>Speech defects/problems</td>
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<tr>
<td>Cardiac disease/disorders</td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
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<tr>
<td>Low Blood Pressure</td>
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<td></td>
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<tr>
<td>Tuberculosis/Lung or Respiratory problems</td>
<td></td>
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<tr>
<td>Hepatitis or any Liver Disease</td>
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<td>Sexually transmitted Diseases</td>
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<tr>
<td>Fainting spells, epilepsy, convulsions or seizures</td>
<td></td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Thyroid disorders/problems</td>
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<td>Kidney or bladder disease</td>
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<td>Cancer</td>
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<td>Back injuries or surgery</td>
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<tr>
<td>Joint injuries or problems</td>
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<tr>
<td>Immunosuppressive therapy</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for chemical/alcohol/drug dependency</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Treatment for emotional/mental health problems</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Additional comments:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

My signature below indicates that I have no injury or illness other than specified on page 1 and 2 of this form. If my condition changes it is my responsibility to notify my instructor of the change. I understand that falsification, omission or misrepresentation of my physical health and abilities will be grounds for dismissal from the Phlebotomy Program.

I attest that I am able to meet the **Technical Performance Standards** for my specific program.

___________________________________________________________________________________________

Signature of student                      Date
## Technical Performance Standards

(As applicable to specific program of study)

The performance standards listed below are required of all students without extraordinary technological enhancements or intermediaries.

<table>
<thead>
<tr>
<th>Applicant must possess sufficient ability to:</th>
<th>Demonstrated by, but not limited to, the following examples: as determined by scope of practice... (with minimal or no assistance/supervision)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Read and communicate orally and in writing using the English language.</td>
<td>Write class assignments; document client care; explain procedures to assigned clients; relate to and communicate with physicians/ members of the health care team, clients, family members and other groups in a manner that is easily understood, organized and accurate.</td>
</tr>
<tr>
<td>2. Hear with or without auditory aids to understand normal speaking voice without viewing the speakers face.</td>
<td>Able to hear monitor alarms and emergency signals at various levels; hears and responds to cries for help without undue delay.</td>
</tr>
<tr>
<td>3. Visually, with or without corrective lenses, observe changes in client’s condition and actively participate in learning process.</td>
<td>Can see small print and numbers on medical supplies; able to read multiple chapters in textbooks; can see instructor or whiteboard in lab/classroom from a distance or up close. Ability to detect color variations.</td>
</tr>
<tr>
<td>4. Utilize stamina, strength and psychomotor coordination necessary to perform routine phlebotomy techniques.</td>
<td>Move in and about client’s room and other work areas of clinical facility; stand/sit/bend/kneel for extended periods of time; lift/move/position and transport clients safely without causing injury/harm/undue pain or discomfort to client, self or others; maneuver and transport equipment safely and in a timely manner; possesses cognitive awareness, stamina and physical strength for assigned procedures.</td>
</tr>
<tr>
<td>5. Demonstrate use of gross and fine motor skills necessary to provide independent, safe and effective phlebotomy techniques.</td>
<td>Set up, calibrate, operate and manipulate all equipment utilized to care for clients within the scope of practice; position clients properly.</td>
</tr>
<tr>
<td>6. Solve problems and apply critical thinking skills while providing safe and efficient client care.</td>
<td>Collect data within scope of practice; use data to plan/implement phlebotomy techniques; respond to emergency situations in a timely manner; utilize good judgment; integrate previously learned material into clinical practice; prioritize and adapt phlebotomy techniques.</td>
</tr>
<tr>
<td>7. Interact with individuals/families/groups from various socioeconomic and cultural backgrounds.</td>
<td>Establish rapport with assigned clients and members of health care team; develop therapeutic listening skills; demonstrate courteous and attentive behavior.</td>
</tr>
<tr>
<td>8. Adapt and function in a multi stressor environment while adhering to legal/ethical guidelines of the school, appropriate accrediting body, and clinical agencies.</td>
<td>Follows all school/department rules and regulations; accepts clinical assignments or changes of such; maintains confidentiality of clients/peers; responds appropriately and quickly to changes in client’s condition; follows directions in mature, professional manner; aware of own learning needs and seeks guidance/resources; reports unsafe/illegal/unethical practices.</td>
</tr>
</tbody>
</table>
Physician: please complete sections 1-6. Incomplete forms will be returned and may delay admission into the Phlebotomy Program.

1. **TB Test - attach copies of the results, including date read or mail to Campus.**
   - Date administered: __________
   - Signature/title of person administering: _________________
   - Date read: __________
   - Results: _____ (mm induration) Read by: _________________ (Include title)

2. **V/S:** Temp ______ P ________ R ________ B/P ________

3. **Review of Systems:** (Please note any abnormalities/problems, even if intermittent, that may affect student’s ability to participate fully in the allied health program)

   - Integumentary: ____________________________________________
   - HEENT: __________________________________________________
   - Neurological: ______________________________________________
   - Cardiovascular: ____________________________________________
   - Respiratory: ______________________________________________
   - GI: _________________________________________________________
   - GU: _________________________________________________________
   - Hearing: ____________________________________________________
   - Teeth: ______________________________________________________
   - (Requires Dental Work ______ Yes ______ No)
   - Vision: _____________________________________________________
   - (Glasses/Contacts ______ Yes ______ No)
   - Color Blindness Test: ______ Passed ______ Failed

4. **Communicable Disease?** ________ Yes ______ No

5. **Does student have any history of or current problems that impair his/her cognitive awareness or physical abilities for any periods of time?** ______ Yes ______ No (if YES, please comment below)

6. **History of EXPOSURE TO TB, HBV or HIV?** ______ Yes ______ No
7. **Prescription medications:** attach letter on *office letterhead* (not prescription pad) attesting that student is able to function effectively and safely in the clinical setting providing services, and/or caring for ill or injured clients with minimal supervision. See TECHNICAL PERFORMANCE STANDARDS.

**For Pregnant Students Only: Please check one.**

- [ ] I have examined this student and she is able to **participate fully** in all activities required.
- [ ] This student is **not able** to participate fully in the program due to complications at this time. Please explain restrictions below.

Unless indicated otherwise, I certify that this student is able to function in a safe and effective manner while caring for ill or injured clients in a clinical setting. The findings indicated above qualify this student both physically and emotionally for enrollment into the program indicated on page 1. He/she is able to **participate fully without special accommodations** in all activities of this program – if special accommodations are required please indicate below. Please comment on any responses above that need further clarification.

Comments: __________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

_____________________________  __________________________
Physician’s signature                      Date
Release and Hold Harmless Agreement/Waiver of Liability Form

I, the undersigned participant, request voluntary training for myself to participate in the Phlebotomy Technician Program which begins on __________ (date) and ends on ____________________ (date) sponsored by South Louisiana Community College (SLCC) all of which are hereafter referred to as the Phlebotomy Technician Program.

I consent to participate in the Phlebotomy Technician Program and acknowledge that I fully understand my participation may involve risk of serious injury or death, including losses which may result not only from my own actions, inactions or negligence, but also from the actions, inactions, or negligence of others, the condition of the facilities, equipment, or areas where the event or activity is being conducted, an/or the rules of play of this type of training. I understand that if I have any risk concerns, I should discuss the risks associated with my participation with the Workforce and Training Coordinator-Kala Marks and/or instructor, before I sign this document and before the training begins. ____

I certify I am in good health and have no physical condition that would prevent training. Furthermore, I agree to use my personal medical insurance as a primary coverage payment if accident or injury occurs. I consent to emergency medical treatment in the event such care is required. ____

I agree that photographs pictures, slides, movies, videos, or other media coverage of me may be taken in connection with my training without compensation from SLCC and the officers, employees, and agents of each of them and consent to use of photographs, pictures, slides, movies, videos, or other media coverage for any legal purpose. ____

Knowing and understanding the risks involved with participation in the training, I hereby voluntarily and willingly assume responsibility for all the risks and dangers associated with my participation in the training. I agree I am financially responsible for any losses resulting from my actions and will indemnify SLCC and the officers, directors, employees, and agents of each of them, for any loss or damage caused by myself during the training. ____

In consideration of my participation in the training, I hereby waive all claims or causes of action against SLCC and the officers, directors, employees, and agents of each of them arising out of my participation in the training and hereby forever release, hold harmless, and discharge SLCC and the officers, directors, employees, and agents of each of them from all liability in connection therewith except as such loss or damage which was caused by the sole negligence or willful misconduct of SLCC and its officers, directors, employees, representatives and volunteers, and the officers, directors, employees, and agents of each of them. ____

I have read this release and hold harmless agreement and understand the terms used in it and their legal significance. This waiver and release is freely and voluntarily given with the understanding that right to legal resource against SLCC and the officers, directors, employees, and agents of each of them is knowingly given up in return for allowing my training in the Phlebotomy Technician Program. My
signature on this document is intended to bind not only myself but also my successors, heirs, representatives, administrators, and assigns. _____

Please utilize the space below to provide any medical/prescription information that you request be released to emergency medical providers.

______________________________________  ____________________
Participat’s Signature  Date

______________________________________  ____________________
Participant’s Signature (print)  (Area Code) Phone Number

______________________________________
Address

______________________________________  ____________________
Emergency Contact Name (print)  (Area Code) Phone Number

________________________________________
Relationship to Participant

List medical/prescription information below:

____________________________________________________
______________________________________
____________________________________________________

______________________________________  ____________________
SLCC Instructor Signature- Print  Date

______________________________________  ____________________
SLCC Instructor Signature  (Area Code) Phone Number