NORTHAMPTON COMMUNITY COLLEGE | CENTER FOR BUSINESS & INDUSTRY
Healthcare Education

Nurse Reactivation for RNs & LPNs

Program Requirements Checklist & Forms
In order to participate in the Nurse Reactivation course, participants must complete the following requirements prior to the first day of class.

Requirements Checklist
All forms are included in this electronic packet.

☐ State nursing license. If your license is inactive, please contact the State Board of Nursing at (717) 783-7142 or www.dos.state.pa.us/nurse. Please bring a copy of your most current nursing license.

☐ Background checks are required by law. Please complete a Pennsylvania Criminal Background Check, FBI Clearance, Child Abuse Clearance and Child Abuse Mandated Reporter. All clearances must be dated within 60 days of the educational experience. You must also complete a signed Felony disclosure form.

☐ Proof of malpractice insurance. If needed, please contact Nurses Service Organization at nso.com or 1-800-247-1500 or another malpractice insurance provider.

☐ Proof of personal health insurance. For those not currently enrolled in a healthcare plan, short- term, personal health insurance coverage may be available through the following website: https://www.pahealthinsurancecoverage.com/short-term-coverage/.

☐ Current BLS certification. If you require certification, please visit www.northampton.edu/cpr.

☐ Complete NCC Health Form, Student Information Form and Student Emergency Contact Form.

☐ Instructions will be provided the first day of class for submissions of clinical requirements and LVHN orientation modules.

☐ Uniform: white uniform top, navy blue uniform pants and uniform shoes or white leather/vinyl sneakers & stethoscope. (Required for clinical)

☐ Purchase textbook. Please note: the following textbook needs to be purchased prior to the start of class and will not be available in the College bookstore.

- RN: Saunders Comprehensive Review for the NCLEX-RN® Examination, 9th Edition, 2019, Silvestri, Linda Anne, ISBN: 978-0323795302
- LPN: Saunders Comprehensive Review for the NCLEX-PN® Examination, 8th Edition, 2019, Silvestri, Linda Anne, ISBN: 978-0323733052

☐ Enroll in the course. Register online at northampton.edu/Lifelearn or by calling 877-543-0998. When registering for RN course, please reference course code NURSE200. When registering for the LPN course, please reference course code NURSE202. Course fee is due at the time of registration via a credit card.

ALL REQUIREMENTS MUST BE COMPLETED PRIOR TO THE FIRST CLASS.
You must bring all completed documents to the first class. For questions, please email healthcare@northampton.edu or call 610-332-6585. For refund information, please visit northampton.edu/NoncreditRefund.

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STUDENT INFORMATION SHEET **Section A**

NORTHAMPTON COMMUNITY COLLEGE

HEALTHCARE EDUCATION

Student Information Sheet

PLEASE PRINT

Name:_____

Preferred or Chosen Name:_____

Address:_____

City/State/Zip:_____

County:_____

Home Phone:_____ Cell Phone:_____

E-mail Address:_____ Social Security No:_____

☐ ***Please check here if we may send you periodic email updates about our classes and programs.***

Date of Birth:_____ Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ SEP

Gender: ☐ Male ☐ Female ☐ Other:_____

Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

NURSING BACKGROUND

1. ☐ RN ☐ LPN Original State/Country of Licensure:_____
2. What is the status of your **Pennsylvania Nursing License**? ☐ Active ☐ Inactive ☐ No License
3. PA License #:_____ Other State License #:_____

WORK EXPERIENCE

1. Are you currently employed in healthcare? ☐ Yes ☐ No
2. If yes, name and location of employer:_____
3. What is your job title?_____
4. If no, length of time out of practice_____
5. Last nursing position_____

MINORITY INFORMATION

The following information is requested to monitor the compliance posture of the institution and will be used only to collect and maintain data on the race, sex, and ethnic identity of all students. This information may be requested on national and state statistical reports. *Please check all that apply to you.* ***(OPTIONAL)***

☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander

☐ Pacific Islander ☐ Caucasian ☐ Hispanic/Latino ☐ Other_____

Language:_____ Have you taken ESL courses? ☐ Yes ☐ No

Primary *Secondary*

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EMERGENCY CONTACT FORM **Section B**

NORTHAMPTON COMMUNITY COLLEGE

Healthcare Education

STUDENT EMERGENCY CONTACT INFORMATION

Please print clearly:

Student Name:_____

Preferred or Chosen Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

EMERGENCY CONTACT(S):

Name:_____

Relationship to Student:_____

Phone:_____ Alternate Phone:_____

Name:_____

Relationship to Student:_____

Phone:_____ Alternate Phone:_____

MEDICAL INFORMATION:

Medical Conditions:_____

Known Allergies to Medications:_____

Other Conditions to be aware of:_____

Hospital Preference:_____

In the event of an emergency, please contact:

Eileen Truscott
Associate Director, Healthcare Education
Northampton Community College

Office Phone: 610-332-6585
Cell Phone: 610-217-6049
E-mail: etruscott@northampton.edu

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NORTHAMPTON
COMMUNITY COLLEGE

****IMPORTANT BACKGROUND CHECK REVIEW PROCESS INFORMATION****

A Pennsylvania State Police Criminal History Report, FBI Criminal History Record Report, and Pennsylvania Child Abuse History Clearance must be completed by all Allied Health students by the deadline noted within this Acceptance Checklist in order to comply with clinical facility requirements. Acceptance is considered conditional until the criminal background check requirement is met. The timeline is established to allow adequate time for the Allied Health Review Committee to review the report and make a recommendation to the Program Director regarding full acceptance into the program. Acceptance will be rescinded if the documents are not received by the deadline.

Students with three (3) reports reflecting "no record" (no convictions) can consider themselves fully accepted.

If there is a positive record, entry into clinical education will be dependent on the decision of the Allied Health Review Committee after the **background clearances, including the RAP sheet,** together with a written, detailed explanation are uploaded to myRecordTracker® (See Section E). Upon receipt of the statement and clearances, the Allied Health Review Committee will review the reports and make a recommendation to the Program Director regarding the student's acceptance into the program. Students will be notified of their status within three (3) days of the committee's review. The student may appeal the decision in writing to the Vice President for Academic Affairs (VPAA) within five (5) working days of notification receipt. The decision of the VPAA is final. The records related to the criminal background process for students will be secured in the Dean's office.

Clinical agencies have the right to deny access to any student with a criminal record based on that site's own criteria. In the event that a student is denied clinical placement based on their criminal record, their acceptance may be rescinded.

The following page contains a list of Prohibitive Offenses which may make it difficult to obtain an internship/externship or employment position within a healthcare facility.

Prohibitive Offenses Contained in 63 P.S. § 675

In no case shall an applicant for enrollment in a State-approved nurse aide training program be admitted into a program if the applicant's criminal history record information indicates a conviction of any of the following offenses:

1. An offense designated as a felony under the act of April 14, 1972 (P.L. 233, No. 64), known as "The Controlled Substance, Drug, Device and Cosmetic Act." (See 35 P.S. § 780-101 et seq.). These offenses may be designated as "CS" on a criminal rap sheet.

2. An offense under one or more of the following provisions of Title 18 of the Pennsylvania Consolidated Statutes below.

3. A Federal or out-of-State offense similar in nature to those crimes listed under paragraphs (1) and (2).

Offense Code	Prohibitive Offense Description	Type/Grading of Conviction
CC2501	Criminal Homicide	Any
CC2502	Murder	Any
CC2503	Voluntary Manslaughter	Any
CC2504	Involuntary Manslaughter	Any
CC2505	Causing or Aiding Suicide	Any
CC2506	Drug Delivery Resulting in Death	Any
CC2507	Criminal Homicide of Law Enforcement Officer	Any
CC2702	Aggravated Assault	Any
CC2901	Kidnapping	Any
CC2902	Unlawful Restraint	Any
CC3121	Rape	Any
CC3122.1	Statutory Sexual Assault	Any
CC3123	Involuntary Deviate Sexual Intercourse	Any
CC3124.1	Sexual Assault	Any
CC3125	Aggravated Indecent Assault	Any
CC3126	Indecent Assault	Any
CC3127	Indecent Exposure	Any
CC3301	Arson and Related Offenses	Any
CC3502	Burglary	Any
CC3701	Robbery	Any
CC3901	Theft	1 Felony or 2 Misdemeanors
CC3921	Theft by Unlawful Taking	1 Felony or 2 Misdemeanors
CC3922	Theft by Deception	1 Felony or 2 Misdemeanors
CC3923	Theft by Extortion	1 Felony or 2 Misdemeanors
CC3924	Theft by Property Lost	1 Felony or 2 Misdemeanors
CC3925	Receiving Stolen Property	1 Felony or 2 Misdemeanors
CC3926	Theft of Services	1 Felony or 2 Misdemeanors
CC3927	Theft by Failure to Deposit	1 Felony or 2 Misdemeanors
CC3928	Unauthorized Use of a Motor Vehicle	1 Felony or 2 Misdemeanors
CC3929	Retail Theft	1 Felony or 2 Misdemeanors
CC3929.1	Library Theft	1 Felony or 2 Misdemeanors
CC3929.2	Unlawful Possession of Retail or Library Theft Instruments	2 Misdemeanors
CC3929.3	Organized Retail Theft	1 Felony or 2 Misdemeanors
CC3930	Theft of Trade Secrets	1 Felony or 2 Misdemeanors
CC3931	Theft of Unpublished Dramas or Musicals	1 Felony or 2 Misdemeanors
CC3932	Theft of Leased Properties	1 Felony or 2 Misdemeanors
CC3934	Theft from a Motor Vehicle	1 Felony or 2 Misdemeanors
CC4101	Forgery	Any
CC4114	Securing Execution of Document by Deception	Any
CC4302	Incest	Any
CC4303	Concealing Death of a Child	Any
CC4304	Endangering Welfare of a Child	Any
CC4305	Dealing in Infant Children	Any
CC4952	Intimidation of Witnesses or Victims	Any
CC4953	Retaliation Against Witness or Victim	Any
CC5902B	Promoting Prostitution	Felony
CC5903C or D	Obscene and Other Sexual Materials and Performances	Any
CC6301	Corruption of Minors	Any
CC6312	Sexual Abuse of Children	Any

Any two Misdemeanor convictions for offenses CC3901 thru CC3934 in any combination is prohibited.

Revised 12/24/2019

POSITIVE BACKGROUND CLEARANCE INFORMATION — Section D

If you have a positive background check, a letter with the information described below must be sent to the program manager, along with your background check results, providing further information on the convictions and non-convictions that appeared on your record. It is important for us to gain as much information as possible about these charges to fairly evaluate your acceptance into the program. To that end, we request that you submit, in writing to the program director, the following information:

1. Date of conviction
2. Exact location
3. Offense(s)
4. How did you plead?
5. What was the outcome/sentencing?
6. Are you still on probation?
7. Provide details surrounding the offense(s) with your version of what happened.

In addition to your written statement, please provide all documentation you may possess that relates to the above record(s). Inability to comply with this request may result in dismissal from the program.

Should you have any questions, please contact Jaye Brennan, Credentialing Coordinator at jpbrennan@northampton.edu or 610-332-6288.

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Submitting a Request for PA Criminal History Record Check (PATCH)

A Pennsylvania Criminal Background Check is required of all NCC Allied Health students. To obtain your record follow the steps below:

1. Go to https://epatch.state.pa.us/Home.jsp.
2. Select the **Submit a New Record Check** option. **Do NOT use the gold box titled "New Record Check (Volunteers only)" option.**
3. Read the **Terms and Conditions** surrounding use of the system in order to proceed with record check request submission. Click on **Accept**.
4. Complete the **Personal Information** form.
   a. Select **Other** from the drop-down list as **Reason for Request**.
   b. Name, address and telephone number are required fields.
5. Click **Next** and the screen will display the personal details entered in the last step. Review details and click the **Proceed** button.
6. Complete the **Record Check Request Form**.
   a. Name, Social Security Number, Date of Birth, Sex, & Race.
   b. List all aliases and/or Maiden Names.
   c. Click **Enter this Request**
7. Confirm the **Record Check Request Review** and click on **Submit**. The charge is **$22.00** per request.
8. Complete the **Credit Card Information** form. PATCH accepts Visa, Discover, Master Card, and American Express. Required information:
   a. Name and address
   b. Credit Card Type and Credit Card Number
   c. Card Verification Method (CVM) number
   d. Expiration Date
9. Click **Next** once the form has been completed.
10. PATCH will display the credit card information entered in the last step. Review the details. Click **Back** if any of the information needs to be changed. Otherwise, click **Submit**.
11. At this point, PATCH will charge the credit card entered for the amount shown. Once the submit button is clicked, this transaction will be processed. This cannot be undone.
12. PATCH will display a summary listing of the Record Check Results.
    a. Details on the record check result can be reviewed by clicking on your name.
    b. Click on the Invoice Number in the Record.
    c. Check Details page to access a printable invoice.
    d. Click on blue link titled **Certification Form** in the Record. This will bring up the record with the State seal. **Please print multiple copies, as you may need this for employment or licensure purposes.**
13. PATCH report will either show:
    a. ***No Record*** status if there are no records found for the request, *or*
    b. ***Request Under Review***. A "Request Under Review" response **does not** necessarily indicate a criminal record. If this occurs, log on to the website daily to check status. You will not be notified when the results are updated. Once the results are in, follow Step 12d. above to access and print the report, including the RAP sheet if the response indicates a criminal record.
14. **IF YOUR CLEARANCE COMES BACK WITH A RECORD,** you must submit the **original**, including the accompanying Rap Sheet, together with a letter of explanation of the charges to the Credentialing Coordinator, since there are additional steps that must be taken for clinical approval. Keep a copy for your records, which may be needed for future employment or volunteer opportunities.

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Submitting a Request for an FBI Criminal Background Clearance

The NCC Allied Health Programs require Federal Bureau of Investigation (FBI) criminal background checks on all students. The fingerprint-based background check is a multiple-step process. Please complete the following steps of the process promptly to assure you meet the **firm deadline** for submitting results. **Please be advised that failure to comply with this requirement by the established deadline will result in cancellation of your acceptance and/or removal from the Allied Health Program**.

1. **Registration:** The applicant must register prior to going to the fingerprint site. Walk in service is allowed but all applicants are required to complete pre-enrollment in the new Universal Enrollment system. Pre-enrollment can be completed online or over the phone. The registration website is available online 24 hours/day, seven days per week at https://uenroll.identogo.com. Telephonic registration is available at 1-844-321-2101 Monday through Friday, 8:00 a.m. to 6:00 p.m. EST. During the pre-enrollment process, all demographic data for the applicant is collected (name, address, etc.) along with notices about identification requirements and other important information.

   When registering online, an applicant must use the appropriate agency specific Service Code to ensure they are processed for the correct agency and/or applicant type. Using the correct service code ensures the background check is submitted for the correct purpose.

Enter Service Code: **1KG756**

When prompted for an employer, enter: Northampton Community College.

2. **Payment:** The applicant will pay a fee of **$23.85** for the fingerprint service and to secure an official copy of the Criminal History Record. Major Credit Cards as well as Money orders or cashier's checks payable to **MorphoTrust** will be accepted on site for those applicants who are required to pay individually. **No cash transactions or personal checks are allowed.**

3. **Fingerprint Locations:** After registration, the applicant proceeds to the fingerprint site of their choice for fingerprinting. The location of the fingerprint sites and days and hours of operation for each site are posted on IDEMIA's website at https://uenroll.identogo.com. The location of fingerprint sites may change over time; applicants are encouraged to confirm the site location nearest to their location.

LOCATION	DAYS	HOURS
HELLERTOWN		
IdentoGO 1866 Leithsville Road Creekside Marketplace Hellertown, PA 18055-2505	Monday – Friday Saturday	09:00 AM - 05:00 PM 09:00 AM - 01:00 PM
ALLENTOWN		
IdentoGO 1382 Hanover Avenue Allentown Commons Plaza Allentown, PA 18109-2019	Monday – Friday	09:00 AM - 12:00 PM *and* 12:30 PM - 04:30 PM
EAST STROUDSBURG		
IdentoGO 5224 Milford Road Suite 155 East Stroudsburg, PA 18302-9671	Monday – Friday Saturday	09:30 AM - 06:30 PM 09:30 AM - 02:30 PM

4. **Fingerprinting**: At the fingerprint site, the Enrollment Agent (EA) manages the fingerprint collection process. The fingerprint transaction begins when the EA reviews the applicant's qualified State or Federal photo ID before processing the applicant's transaction. A list of approved ID types may be found on the IDEMIA website at https://uenroll.identogo.com. **Applicants will not be processed if they cannot produce an acceptable photo ID.** After the identity of the applicant has been established, all ten fingers are scanned to complete the process. The entire fingerprint capture process should take no more than three to five minutes.

ACCEPTABLE DOCUMENTS
➢ Canadian Commercial Driver's License (CDL) ➢ Commercial Driver's License issued by a State or outlying possession of the U.S. ➢ Department of Defense Common Access Card ➢ Driver's License PERMIT issued by a State or outlying possession of the U.S. ➢ Driver's License issued by a State or outlying possession of the U.S. ➢ Employment Authorization Card/Document (I-766) with Photo ➢ Enhanced Tribal Card (ETC) ➢ Foreign Driver's License (Mexico and Canada Only) ➢ Foreign Passport ➢ Merchant Mariner Document (MMD) ➢ Military Dependent's Card ➢ Military ID Card ➢ Passport Book or Card ➢ Permanent Resident Card / Green Card (I-551) ➢ Photo ID Waiver for Minors ➢ State ID Card (or outlying possession of the U.S.) with a seal or logo from State or State Agency ➢ Uniformed Services Identification Card (Form DD-1172-2) ➢ Visa

5. Once uploaded, check with your Program Director to determine if you are required to submit the **original** document to the College as part of fulfilling your clinical requirement.

7. **IF YOUR CLEARANCE COMES BACK WITH A RECORD,** you must submit the **original**, including the accompanying Rap Sheet, together with a letter of explanation of the charges to the Credentialing Coordinator, since there are additional steps that must be taken for clinical approval. Keep a copy for your records, which may be needed for future employment or volunteer opportunities.

Submitting a Request for Child Abuse Clearance

A Child Abuse History Clearance is required of all NCC Allied Health students. **Child Abuse Clearances can now be requested online, but it may still take several weeks to receive the results.**

Please note: Failure to follow the instructions below may cause a considerable delay in processing of your application and could affect your ability to meet the deadline for submitting results. Please be advised that failure to comply with this requirement by the established deadline will result in cancellation of your acceptance and/or removal from the Allied Health Program.

1. Please go to the **PA Child Welfare Information Solution Portal** at https://www.compass.state.pa.us/CWIS.

2. Select "**Create Individual Account**" and follow the instructions to create a Keystone ID account. You will be asked to provide some personal information and answer security questions.
    A. Creation of your Keystone ID will prompt their system to send you two e-mails. One will contain confirmation of your recently created Keystone ID and the other will provide you with a temporary password.
    B. Go back to the Child Welfare Portal website at https://www.compass.state.pa.us/CWIS and choose the "**Individual Login.**" Choose "**Access my Clearance**". Read "**Learn More**" and scroll down to "**continue**" in order to login.
    C. Login by using your Keystone ID using the temporary password copied and pasted from the email sent to you.
    D. Once logged in, the system will require you to immediately change the password. Set permanent password and click "**Submit**". The website will then tell you to click on "**Close Window**" button.
    E. Login again to your application with your Keystone ID and newly created personal password.

3. Review "**My Child Welfare Account Terms & Conditions.**"
    a. Choose to accept the Terms & Conditions and click "**Next.**"
    b. On the "My PA Child Abuse History Clearances" screen choose "**Create Clearance Application**."

4. Review "**Getting Started**", scroll to bottom and select "**Begin**". Complete the Application Part I & Part II in full.
    a. Part I consists of the following sections: Application Purpose, Application Info, Current Address, Previous Address, Household Members, & Application Summary. (The form asks for all previous names, addresses, and household members since 1975). This information must be provided to the best of your knowledge and belief.
    b. Part II consists of the following sections: eSignature and Application Payment.

5. Part I / Section I "**Application Purpose**".
    a. Choose the first option "**Volunteer Having Contact with Children**"
    b. Below this a box will appear. Choose "**Other**" under the Voluntary Category. Type "**Northampton Community College**" under Agency Name.

6. Part II - Finish completing application process. Payment of $13.00 is required at time of request. Debit or credit cards will be accepted. **If the system gives you the option to print the results out immediately as well as have one sent to you in the mail, please choose both options.**

7. **IF YOUR CLEARANCE COMES BACK WITH A RECORD,** you must submit the **original**, including the accompanying Rap Sheet, together with a letter of explanation of the charges to the Credentialing Coordinator, since there are additional steps that must be taken for clinical approval. Keep a copy for your records, which may be needed for future employment or volunteer opportunities.

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Child Abuse Mandated Report Training

The online Child Abuse Mandated Reporter Training must be completed for the Allied Program you are completing.

7. The course is offered free of charge through the University of Pittsburgh.

8. Please access the course by copying and pasting the link below:

   https://www.reportabusepa.pitt.edu/webapps/portal/execute/tabs/tabAction?tab_tab_group_id=_2_1.

9. Click on the "Registration" link at the top of the page and create an account. Be sure to save your login information for future use.

10. The course may take up to three hours to complete but does not have to be done all at once. You may save your progress and return to it at another time using your login information.

11. At the end of the course, you will be prompted to print your Certificate of Completion. Be sure to print out multiple copies for your records since you may need it for licensure.

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NORTHAMPTON
COMMUNITY COLLEGE

Student Release of Information Form
For Allied Health Clinical Sites Only

The Family Educational Rights and Privacy Act of 1974 (FERPA) protects the student's educational record from disclosure to unauthorized individuals. As an admitted and enrolled student in the NCC Allied Health program, additional documentation is required to be submitted, including criminal background checks and drug screening results. While these items are not part of the student educational record, they are maintained as confidential by the program/division. Northampton Community College is required to share positive results of criminal background checks and drug screening with any affiliated institution used for clinical education in the Allied Health programs.

I understand that information regarding these results will be released to the requestor according to the guidelines outlined in the affiliation agreement between the college and the clinical affiliate.

I understand that the clinical affiliate requires that positive results of my background check(s) be shared with the following individuals: the VP Human Resources, Labor/Employment Counsel, VP Patient Care Services, and/or the manager(s) of the unit where the student is assigned for clinical.

In connection with my admission and enrollment in an NCC Allied Health Program and my participation in the Program's clinical training opportunities, I hereby authorize the College and its agents to release any and all information relevant to my criminal record and/or drug screen results to any authorized clinical site representative it deems appropriate in order to determine my suitability to be enrolled in the Allied Health Program and/or to be assigned to a clinical site selected by the College. A photocopy of this release will be sufficient to authorize the release of the information.

Student Information:
(*Please print legibly*)

_____
Student ID

_____
Student's Name (Last) (First) (Middle) (Previous)

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

_____ _____
Primary Phone Number Secondary Phone Number

_____ _____
Signature of Student Authorizing Release Date

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Student Health Requirements

Attached is the NCC health form that must be completed and **uploaded** to myRecordTracker®. All health-related information must be uploaded by the due date given in order to continue in the program. **Failure to upload all of the required information by the due date will result in dismissal from the program.**

The Health and Wellness Center at Northampton Community College is operated by St. Luke's University Health Network, Bethlehem, PA. Physical examinations and some of the required immunizations may be obtained at the Health and Wellness Center. Please call 610-861-5365 for more information or to schedule an appointment. You may also contact St. Luke's Urgent Care Center, 153 Brodhead Road, Bethlehem, PA, 610-954-3220, to make an appointment for health services if you do not have your own family physician.

Health insurance is **required** for all Allied Health Programs and must be maintained throughout the duration of the Program. It is the student's responsibility to upload a copy of the front and back of the new insurance card immediately.

The checklist below provides an overview of what must be completed on the Health Form. Please be sure to check form BEFORE leaving Medical Provider's Office to ensure all items are completed.

PAGE 1 – Student Information (to be completed by student)		
☐	Personal Information	• Student to complete and sign first page of health form
☐	Health Insurance	• Students **must** have personal health insurance • Complete health insurance section on first page
PAGE 2 – Physical (to be completed by physician)		
☐	Physical Performed by Medical Provider	• Bring health form **and OSHA form** to scheduled appointment • Medical provider MUST clear student for N95 fit testing • Be sure provider initials all boxes on Page 2 of Health Form and also signs form
PAGE 3 – Immunizations, Vaccinations, and Titers (Bloodwork)		
☐	Varicella	• Must show proof of two Varicella vaccinations – *OR* – • Titer to prove immunity • Proof of disease is NOT acceptable
☐	MMR	• Must provide proof of two MMR vaccinations – *OR* – • Titer to prove immunity
☐	Hepatitis B	• Must provide proof of three Hepatitis B vaccinations
☐	Hepatitis B Surface Antibody – **QUANTITATIVE Titer** ******REQUIRED******	• **Must** obtain Hep B Surface Antibody in addition to Hep B vaccination dates **to show immunity or lack of immunity** • This is **required** and must be done immediately in case further vaccinations are needed
☐	Hepatitis B Booster or Repeat Series	• Start immediately ONLY if antibody titer shows no (repeat all 3 doses) or low (get booster dose) immunity.
☐	TDAP	• Proof of TDAP dated **within 10 years**
☐	Influenza Vaccination *(Seasonal)*	• Required for all classes
☐	COVID-19 Vaccination	• Must provide proof of COVID-19 vaccination(s) as mandated and boosters warranted (see myRecordTracker instructions)
PAGE 4 – TB Testing (to be completed by physician or clinical staff)		
☐	Step #1 TB Test Results ***(must be within 12 months of clinical)***	• 1st TB test must be administered, and results documented 48-72 hours later
☐	Step #2 TB Test Results ***(must be within 3 months of clinical)***	• One week after 1st test is read, have second test administered, and results documented 48-72 hours later
☐	**IMPORTANT NOTE REGARDING TB TESTING:** • QuantiFERON blood testing may be administered in place of the two-step TB testing. • QuantiFERON or chest x-ray must be performed in the event of any positive results from the skin testing.	

NORTHAMPTON
COMMUNITY COLLEGE

NCC Health & Wellness Center

Main Campus ♦ College Center ♦ Room 120
3835 Green Pond Road ♦ Bethlehem, PA 18020
Phone: 610-861-5365 ♦ Fax: 610-861-4545

NCC Health & Wellness Center Physical Exam and Health Requirement Options		
Physical Exams	$25.00 *(by appointment only at the Health & Wellness Center)*	$45.00 *(at St. Luke's North*)*

Required Vaccines/Titers		
IMMUNIZATION	**VACCINE PRICES**	**TITER PRICES**
	*Available at both the Health & Wellness Center and St. Luke's North**	*Available at St. Luke's North* only*
Hepatitis A (per dose)	$65.00 *(2 doses needed)*	
Hepatitis B (per dose)	$60.00 *(3 doses needed)*	$30.00
Meningitis (Menactra)	$130.00	
MMR (per dose)	$70.00 *(2 doses needed)*	$219.50 *(for all 3 titers)*
Tetanus (Tdap)	$40.00 *(includes pertussis)*	
Tuberculin Skin Test (PPD)	$10.00 *(per test)*	
Varicella	$135.00	$42.60

** St. Luke's North may also charge an administration fee.*

☐ CHE Instructor
☐ Dental Assisting
☐ Nursing Reactivation
☐ Phlebotomy Technician
☐ Other_____

NORTHAMPTON COMMUNITY COLLEGE

HEALTHCARE EDUCATION HEALTH FORM

For questions about health requirements, please contact:

Healthcare Education

Northampton Community College
Fowler Family Southside Center
511 E. Third Street, Suite 350
Bethlehem, PA 18015

Phone: 610-332-6585
Fax: 610-332-6556
healthcare@northampton.edu

PART I – REPORT OF MEDICAL HISTORY

Please complete *(print all sections)*. **International students: please provide all health documents translated into English.**

Student Name:_____ **Student ID #:**_____
Last *First* *Middle*

Home Address: _____ Gender: ☐ Male ☐ Female ☐ Other_____

City/State/Zip: _____ Preferred: ☐ He/Him ☐ She/Her ☐ They/Them

Home Phone: _____ Cell Phone:_____

Email Address: _____ **Date of Birth**:_____

Program/Major: _____ On Campus Housing: ☐ Yes ☐ No

Semester: ☐ FA ☐ SP ☐ SU Year_____ Campus: ☐ Main ☐ Fowler ☐ Monroe

I. EMERGENCY NOTIFICATION

Name of Contact:_____ Relationship:_____

Home Address:_____ City/State/ Zip:_____

Primary Phone:_____ Alternate Phone:_____

II. **MEDICAL HISTORY** – Please answer yes or no to all questions and insert the year for all positive answers:

	Yes	No	Please Explain
Allergies			
Asthma			
Cardiac			
Chemical Dependency			
▪ Drugs			
▪ Alcohol			
Diabetes Mellitus			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular			
Orthopedic Condition			
Respiratory Illness			
Seizure Disorder			
Vision Disorder			
Other (Specify)			

ACCIDENT AND HEALTH INSURANCE (Required) – Student must upload a copy of current health insurance card (front and back) to myRecordTracker®. Student is required to have valid health insurance for the duration of the program and must notify the Credentialing Coordinator of any change in health insurance which occurs during the program, and upload a copy of the new insurance card.

If the above-named emergency contact cannot be reached at the time of an emergency, the College is authorized to send the above-named student to the nearest hospital and/or to administer necessary emergency care. In addition, I authorize the release of information regarding my health/medical status to the Program Director and appropriate designee(s), to the Northampton Community College Health and Wellness Center, to the appropriate health care agency in which I am completing clinical requirements, and/or to the above-named emergency contact.

_____ _____
Student signature (Parent/Guardian if under 18 years of age) *Date*

PART II-REPORT OF MEDICAL EXAMINATION

A physical examination completed **within 6 months of the start of the clinical experience** by a licensed medical provider (MD, DO, CRNP, or PA-C) is **required** prior to entry into clinical practice. Clinical work is **PROHIBITED** until the required medical forms are uploaded and verified.

Name:_____ **Student ID:**_____ **DOB:**_____

I. Height_____ Weight_____ Blood Pressure_____ Pulse_____

II. Vision Uncorrected R_____ L_____

Corrected R_____ L_____

III. Clinical Examination: *Describe details of abnormalities* **Date of Examination**:_____

	Normal	Abnormal	Comments
Skin			
Head and scalp			
Eyes			
Ears/Hearing			
Mouth, Nose, Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurological			
Psychiatric			
Exposure to Hepatitis A, B, or C			*If positive for exposure, please submit titers.*

Allergies	
Medications taken on a regular basis	

****IMPORTANT** LICENSED PROVIDER, PLEASE INITIAL TO CERTIFY THE FOLLOWING:**	**INITIALS**
I certify that the applicant is free from communicable diseases in the communicable state.	
I certify that the applicant has no medical conditions or restrictions which will prevent the applicant from performing the essential functions of the job. (If the applicant has restrictions that require accommodation, please note them in the comments section below.)	
Comments *(if applicant has any limitations, please explain)*:	

Please print, type or stamp:

Name of Licensed Provider_____

Address:_____

Phone_____

Signature of Licensed Provider_____ Date_____

CLINICAL REQUIREMENTS

To meet the requirements set forth by NCC, Clinical Sites and OSHA, you will need to obtain and upload to myRecordTracker® documentation for the following immunizations and tests before beginning your experience at Clinical Sites.

IMMUNIZATIONS (Vaccinations)

All students are required to UPLOAD **immunization records** to myRecordTracker® for the following:

- **Varicella** (Chickenpox) – 2 doses after age 12 months
- **MMR*** – 1st dose after age 12 months, and 2nd dose after age 4 years
- **Hepatitis B** – 3 doses
- **TDAP** – Tetanus Diphtheria Acellular Pertussis *(Dated within 10 years)*
- **Influenza** – Current Season *(Required if participating September – April)*

HEPATITIS B SURFACE ANTIBODY, QUANTITATIVE TITER

- **All Students** are required to obtain the **Hepatitis B Surface Antibody, QUANTITATIVE Titer** to determine immunity status and UPLOAD the **lab report** to myRecordTracker®. **Titer results must be dated within the past three years.**

HEPATITIS B REPEAT SERIES OR BOOSTER *(Required if titer shows no or low immunity)*

- If the Hepatitis B Surface Antibody, Quantitative Titer shows no immunity, the repeat series of three doses should be started immediately.
- If the titer shows low immunity, a booster dose should be given immediately. The repeat titer should be given one month after the booster or last dose.
- Any repeat doses, booster, and titer reports must be uploaded to myRecordTracker® each time they are received.

COVID-19 VACCINATION AND BOOSTER RECORDS

- COVID-19 Vaccinations are required by major healthcare networks to protect yourself and others while working in healthcare. Please upload proof of full vaccination (one dose of J & J, or two doses of the Pfizer or Moderna vaccines). You will be required to provide a copy of your COVID-19 vaccination card to your internship/externship site.
- If you have received a COVID-19 booster, please provide proof, although not mandatory at this time.

TITERS (Bloodwork)

- **If immunization records are not available,** students are required to obtain titers to determine immunity status for the above listed requirements. **All titer results must be dated within three years.**
- Documentation of the Chickenpox disease is not considered acceptable for immunity, and a titer must be drawn.

SUPPORTING DOCUMENTATION OPTIONS

- Immunization records can include your childhood and/or school immunization records – or a printout from your medical provider.
- Lab reports must contain titer results **dated within the past three years** showing level of immunity.

Name:_____ **Student ID #**_____

Last *First* *Middle*

TUBERCULOSIS SCREENING REQUIREMENTS

In order for any student to observe in any area of the Clinical Site, Tuberculosis screening must be administered and documented and may be obtained by skin testing or blood test. **Two** TB skin tests are required **within 12 months, the most recent within 3 months, of the start of your Clinical Experience**. A QuantiFERON-TB Gold blood test may be administered **within 3 months of the start of your Clinical Experience,** in lieu of the two TB skin tests. **Document the results below and/or upload relevant documentation.**

***** If results are positive (greater than 10mm induration), or if there is any history of a previous positive TB test, either the QuantiFERON-TB Gold blood test or chest x-ray must be performed.***

A. **Two TB Skin Tests** - within 12 months, **the most recent within 3 months**, of the start of the clinical experience.

STEP 1	Date	Arm	Results (mm)	Signature
Administered				
Results Read			☐ (+) ☐ (-) ____mm	

***** AND *****

STEP 2	Date	Arm	Results (mm)	Signature
Administered				
Results Read			☐ (+) ☐ (-) ____mm	

OR -

B. **QuantiFERON-TB Gold or T-SPOT-*TB* blood test** - within **3 months** of the start of the clinical experience:

MUST UPLOAD COPY OF LAB REPORT.

OR -

C. **Chest X-Ray** - within **6 months** of the start of the clinical experience:

MUST UPLOAD COPY OF CHEST X-RAY REPORT.

NOTE: *TB testing can be administered at the location of the student's choice (i.e., private physician's office, NCC Health and Wellness Center, or at any clinic.) The student is responsible for any and all charges.*

TO BE COMPLETED BY MEDICAL PROVIDER WHEN TB RESULTS ARE VERIFIED:

Please print, type or stamp:

Name of Licensed Provider_____

Address:_____

Phone_____

Signature of Licensed Provider_____ Date_____

OSHA INFOSHEET

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method. To facilitate these medical evaluations, this INFOSHEET includes the mandatory medical questionnaire to be used for these evaluations.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Once filled out, this form must be given to the PLHCP. This form should **not** be submitted to OSHA.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex: ○ Male ○ Female
5. Your height: ____ ft. ____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire: ○ Yes ○ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): ○ Yes ○ No If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	○	○
2. Have you *ever had* any of the following conditions?		
a. Seizures	○	○
b. Diabetes (sugar disease)	○	○
c. Allergic reactions that interfere with your breathing	○	○
d. Claustrophobia (fear of closed-in places)	○	○
e. Trouble smelling odors	○	○
3. Have you *ever had* any of the following pulmonary or lung problems?		
a. Asbestosis	○	○
b. Asthma	○	○

	YES	NO
c. Chronic bronchitis	○	○
d. Emphysema	○	○
e. Pneumonia	○	○
f. Tuberculosis	○	○
g. Silicosis	○	○
h. Pneumothorax (collapsed lung)	○	○
i. Lung cancer	○	○
j. Broken ribs	○	○
k. Any chest injuries or surgeries	○	○
l. Any other lung problem that you've been told about	○	○
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	○	○
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	○	○
c. Shortness of breath when walking with other people at an ordinary pace on level ground	○	○
d. Have to stop for breath when walking at your own pace on level ground	○	○
e. Shortness of breath when washing or dressing yourself	○	○
f. Shortness of breath that interferes with your job	○	○
g. Coughing that produces phlegm (thick sputum)	○	○
h. Coughing that wakes you early in the morning	○	○
i. Coughing that occurs mostly when you are lying down	○	○
j. Coughing up blood in the last month	○	○
k. Wheezing	○	○
l. Wheezing that interferes with your job	○	○
m. Chest pain when you breathe deeply	○	○
n. Any other symptoms that you think may be related to lung problems	○	○
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack	○	○
b. Stroke	○	○
c. Angina	○	○
d. Heart failure	○	○

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	○	○
f. Heart arrhythmia (heart beating irregularly)	○	○
g. High blood pressure	○	○
h. Any other heart problem that you've been told about	○	○
6. Have you *ever had* any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	○	○
b. Pain or tightness in your chest during physical activity	○	○
c. Pain or tightness in your chest that interferes with your job	○	○
d. In the past two years, have you noticed your heart skipping or missing a beat	○	○
e. Heartburn or indigestion that is not related to eating	○	○
f. Any other symptoms that you think may be related to heart or circulation problems	○	○
7. Do you *currently* take medication for any of the following problems?		
a. Breathing or lung problems	○	○
b. Heart trouble	○	○
c. Blood pressure	○	○
d. Seizures	○	○
8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9.) ☐	○	○
a. Eye irritation	○	○
b. Skin allergies or rashes	○	○
c. Anxiety	○	○
d. General weakness or fatigue	○	○
e. Any other problem that interferes with your use of a respirator	○	○
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐		

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever* lost vision in either eye (temporarily or permanently)?	○	○
11. Do you *currently* have any of the following vision problems?	○	○
a. Wear contact lenses	○	○
b. Wear glasses	○	○
c. Color blind	○	○
d. Any other eye or vision problem	○	○

	YES	NO
12. Have you *ever had* an injury to your ears, including a broken eardrum?	○	○
13. Do you *currently* have any of the following hearing problems?	○	○
a. Difficulty hearing	○	○
b. Wear a hearing aid	○	○
c. Any other hearing or ear problem	○	○
14. Have you *ever had* a back injury?	○	○
15. Do you *currently* have any of the following musculoskeletal problems?	○	○
a. Weakness in any of your arms, hands, legs, or feet	○	○
b. Back pain	○	○
c. Difficulty fully moving your arms and legs	○	○
d. Pain and stiffness when you lean forward or backward at the waist	○	○
e. Difficulty fully moving your head up or down	○	○
f. Difficulty fully moving your head side to side	○	○
g. Difficulty bending at your knees	○	○
h. Difficulty squatting to the ground	○	○
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	○	○
j. Any other muscle or skeletal problem that interferes with using a respirator	○	○

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

U.S. Department of Labor

OSHA® Occupational Safety and Health Administration

DTSEM OSHA 3789-05 2015

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NORTHAMPTON COMMUNITY COLLEGE

FIT TEST MEDICAL CLEARANCE

OSHA Form Review

Healthcare Education Programs

Name:_____
Last *First* *Middle*

DOB:_____ Student ID:_____

	Program of Study			Healthcare Education Instructor
☐	Dental Assisting		☐	Nurse Aide Instructor
☐	Nursing Reactivation		☐	Nursing Reactivation Instructor
☐	Phlebotomy		☐	Phlebotomy Instructor
☐			☐	

I hereby certify that I have reviewed the attached OSHA Form for the above-named individual, and this individual is medically cleared to be fit tested for a N95 respiratory face mask.

To be completed by medical provider:

Please print, type, or stamp:

Name of Licensed Provider:_____

Address:_____

Phone:_____

Signature of Licensed Provider:_____ Date:_____

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CASTLE BRANCH BRIDGES– LVHN ORIENTATION INSTRUCTIONS Section L

Lehigh Valley Health Network has a separate orientation for the clinical component of this course that will be done through an online program called CastleBranch Bridges. Once you have started the course, we will give you instructions to create your CastleBranch account and begin your orientation.

Orientation consists of tiles that you will complete. Some are simple online forms to fill out. Others are modules that you will need to read or view regarding infection control or logistics such as parking at the facility.

Please be prepared for this orientation by making the appointment for your physical exam early. You will need to bring your completed OSHA form to your appointment to be cleared for fit testing which is one of the required items for orientation.

You will need to provide the following information for CastleBranch Bridges:

- Fit Testing Certificate
- Current verification of flu vaccine
- TB documentation (with the last TB being no more than 3 months before your clinical start date)
- COVID vaccine verification (not mandatory yet, but it is still being tracked)

Instructions to create your CastleBranch Bridges account will be given on the first day of class. Please use this time to prepare the necessary requirements.

There will also be an online daily screening you will need to do before going to clinical each day.

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URINE DRUG SCREENING REQUIREMENTS

NCC's Allied Health programs are affiliated with healthcare providers throughout the region. A number of these facilities now require students participating in clinical education at their site to have drug screens completed prior to attending clinical.

When do I go for my drug screen?

At a later date to be determined, you will be given information and dates to have your drug screen done. **YOU WILL ONLY BE GIVEN 24-48 HOURS' NOTICE**. This may be done during class, or you may be required to go to St. Luke's North or another facility. If it is done during class and you are absent on the day of testing, you will be required to go to St. Luke's North by the end of that same business day. It is important that you obtain your drug test in the specified time frame in order for St. Luke's to process and deliver the results in a timely manner.

Where do I go to have the drug screen done?

St. Luke's North is our preferred provider for these drug screens, and they are aware of NCC Allied Health student requirements. The test may be performed during class or at their site at NCC's discretion, and St. Luke's will communicate the results directly to the NCC authorized NCC Staff. Allied Health program directors will communicate with the authorized NCC staff to ensure that all students are compliant with the requirement and all student results are negative.

What should I bring with me?

You should bring the drug screen form that will be given to you in class, as well as photo identification and payment.

What is the cost of the test?

The current cost* of the test is $34 and is due at time of service. Payment may be made by cash or check payable to St. Luke's. ****Cost is subject to change during the course of the academic year.****

What if my drug screen is positive?

Students will only be permitted to attend clinical education if they have a negative drug screen. Any student with a positive screen will be immediately withdrawn from the program.

What if my provider has prescribed Medical Marijuana?

NCC has a policy for addressing the use of medical marijuana that you are able to read prior to enrolling in this program so that you are aware of the policy and its potential effects of your ability to complete this program.

REMINDER: Plan now so that you have your payment money available at any time but DO NOT OBTAIN DRUG SCREEN NOW!

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Health Careers Medical Marijuana Policy

In order to be transparent regarding the entire drug screening process and the use of Medical Marijuana, Northampton Community College recognizes our responsibility to fully inform students of NCC's policy at the time of acceptance. Please read the following policy carefully and acknowledge your understanding by signing and uploading this form to myRecordTracker.

The Pennsylvania Department of Health is currently implementing the Pennsylvania Medical Marijuana Program, a component of the Medical Marijuana Act (MMA) that was signed as law on April 17, 2016. This program provides access to medical marijuana for patients with serious medical conditions as defined by the Pennsylvania Department of Health.

At this time, the Federal government regulates drugs through the Controlled Substances Act, which does not recognize the difference between medical and recreational use of marijuana. Under Federal law, marijuana is a Schedule 1 controlled substance, meaning that it is considered to have no medical value. Medical practitioners may not prescribe marijuana for medical use under Federal law.

Students entering any Health Science Careers Program are required to have urine drug screenings upon admission to the clinical phase of the program and on a yearly basis while participating in clinical experiences. As per current policy, if the results are positive, the student will be dismissed from the program immediately and referred for appropriate counseling.

Students using medical marijuana will not be eligible for clinical, internship, or externship placement in any NCC health science career program, due to the current discrepancy between State and Federal law regarding Drug Free Work Place Act and the MMA. Businesses who are not in compliance with Federal law are at risk for criminal or civil charges; and additionally, may find issue with eligibility for Federal contracts and grants. Additionally, Pennsylvania's Medical Marijuana statute specifically provides that an employer does not have to accommodate an individual in a safety sensitive position if that person is under the influence of medical marijuana. Most positions involving direct patient care will be considered safety sensitive positions.

Students should also understand that under current Pennsylvania State Board law, many health career licensing boards require drug screening at the time of application for licensure. Similarly, most health care employers will perform routine drug screening as a condition for employment, as these positions involve direct patient care, and are considered safety sensitive positions. **This discrepancy between Federal and State law allows our clinical partners to deny student placement for clinical experiences and the State of Pennsylvania to deny licensure.**

Due to current laws, NCC cannot provide admission to the clinical phase in any of our Health Science Career Programs and students who have been admitted and are later to be found positive for medical marijuana will be dismissed from the Program.

_____

I hereby acknowledge that I have read and understand NCC's Health Careers Medical Marijuana Policy.

_____

Student's Name (Please Print)

_____ _____

Signature of Student *Date*