MILWAUKEE AREA **Technical College**

Medical Assistant

Health Requirements Checklist

All MATC Health Science students are required to complete and upload health requirements prior to petitioning for courses which contain a clinical component. MATC School of Health Sciences has partnered with CertifiedBackground.com to provide health record tracking for all MATC Health Sciences students. The cost of the health record tracking ($35) is the responsibility of the student.

Use the steps below to complete the CertifiedBackground (CB) electronic health record tracking process.

1. Visit CertifiedBackground.com website: www.certifiedbackground.com
2. Click on Student
3. Enter the **package code MF34im** (package code is specific to the Medical Assistant program)
4. Follow the directions to setup your CB account

* The cost of the health examination and immunizations are your responsibility. You may be able to obtain health care services at your local Health Department or you may call 1-866-211-3380 for a list of clinics in your area.

* If a student is accepted into core technical courses via petitioning, he or she will receive instructions for completing a mandatory drug test. The cost for the drug test is an additional $34 per a test.

TO DO:

☐ **Acknowledgment of Essential Functions-**Functional Abilities Form

☐ **Health Certification Requirements**

1) ☐ **Certification of student's good health by a physician, physicians assistant or nurse practitioner.**

2) ☐ **Immunizations**

   a) ☐ MMR immunizations shots **1 <u>and</u> 2** **<u>OR</u>**

   b) ☐ Rubella **<u>AND</u>** Rubeola titer (Lab results must be attached)
   <u>AND</u>

   c) ☐ Chicken pox - Proof of having had chicken pox or chicken pox immunization per authorized medical signatures **<u>OR</u>** Varicella titer (Lab results must be attached)

3) ☐ **TB skin test, Step 1 <u>and</u> Step 2**
(2 negative TB skin tests within 30 days of each other)

   a) ☐ Chest x-ray, only if TB skin test was positive
   b) ☐ Quantiferon TB Gold blood test option

4) ☐ **Tetanus Shot**

5) ☐ **Hepatitis B Release Form -** Signed and verifying Hepatitis B status

6) ☐ **CPR –** American Heart Association, Healthcare Provider (upload a copy of the card)

7) ☐ **Health Sciences Handbook Acknowledgment Form**

8) ☐ **Clinical/Field Placement Liability Release Form**

9) ☐ **First Aid Certification** – (upload a copy of the card)

MILWAUKEE AREA TECHNICAL COLLEGE
School of Health Sciences
Essential Functions
for the
Medical Assistant Program

The Americans with Disabilities Act (ADA) prohibits discrimination of persons with disabilities. In keeping with this law, MATC makes every effort to insure quality education for all students. It is our obligation to inform students of the essential functions necessary for this program and occupation.

Students requiring accommodation and/or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

The following physical, cognitive and environmental performance standards are encountered by students in this program.

ESSENTIAL FUNCTIONS

	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
SPEECH							
Speak English with Clarity				X		X	
Communicate in English with Clarity				X		X	
HEARING							
Conversation				X		X	
Telephone				X		X	
SIGHT							
Natural or Corrected Without Assistance				X		X	
Depth Perception				X		X	
Color Vision				X		X	
MOBILITY using each extremity (right and left) as applicable							
Lift, Push or Pull 50 lbs.		X				X	
Shoulder				X		X	
Arm				X		X	

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MILWAUKEE AREA TECHNICAL COLLEGE
School of Health Sciences
Essential Functions
for the
Medical Assistant Program

	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Neck				X		X	
Standing				X		X	
Move about Facility				X		X	
Bending			X			X	
Crawling		X					X
Kneeling		X					X
Twisting Body				X		X	
Running		X					X
Walking				X		X	
Climbing							
Stairs		X					X
Other (ladder)		X				X	
REACHING using each extremity (right and left) as applicable							
Overhead				X		X	
In Front of Body				X		X	
Down				X		X	
GRASPING							
Overhead				X		X	
In Front of Body				X		X	
Down				X		X	
SITTING			X			X	
SMELLING			X			X	
TASTING							X
FINE MOTOR CONTROL (working with small objects and using each hand (right and left).							
Hands				X		X	
Fingers/Tactile Sense (the				X		X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
ability to feel when touching)							
Wrist				X		X	
COORDINATION							
Eye/Hand with both hands/arms				X		X	
Eye/Hand/Foot with both hands/arms/feet				X		X	
ALLERGIES/ SENSITIVITIES							
Tolerance to Latex		X					
COGNITIVE/MENTAL FACTORS							
REASONING							
Deal with abstract and concrete variables, define problems, collect data, establish facts, and draw valid conclusions						X	
Interpret instructions furnished in oral, written, diagrammatic, or schedule form						X	
Deal with problems from standard situations						X	
Carry out detailed but uninvolved written or oral instructions						X	
Carry out one or two step instructions						X	
MATHEMATICS							
Complex skills - Business math, algebra, geometry or statistics							X

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Simple skills - add, subtract, multiply and divide whole numbers and fractions, calculate time and simple measurements						X	
READING (All apply in English)							
Complex skills - Comprehend medical records, manuals, journals, instructions in use and maintenance of equipment, safety rules and procedures and drawings						X	
Simple skills - Comprehend simple instructions or notations from a log book						X	
Ability to read data on paper and then input it on a computer screen						X	
WRITING (All apply in English)							
Complex skills - Prepare medical documentation, report summaries using prescribed format and conforming to all rules of punctuation, spelling, grammar, diction and style						X	
Simple skills - English sentences containing subject, verb and object; names and addresses, complete job application or notations in a log book						X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
PERCEPTION							
Spatial - ability to comprehend forms in space and understand relationships of plane and solid objects; frequently described as the ability to "visualize" objects of two or three dimensions, or to think visually of geometric forms						X	
Form - ability to perceive pertinent detail in objects or in pictorial or graphic material; to make visual comparisons and discriminations and see slight differences in shapes and shadings of figures and widths and lengths of line						X	
CLERICAL (All apply in English)							
Ability to perceive pertinent detail in verbal or tabular material; to observe differences in copy, to proof-read words and numbers, and to avoid perceptual errors in arithmetic computation.						X	
DATA							
Synthesizing						X	
Coordinating						X	
Analyzing						X	
Compiling						X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Computing						X	
Copying						X	
Comparing						X	
PERSONAL TRAITS							
Ability to comprehend and follow instructions						X	
Ability to perform simple and repetitive tasks						X	
Ability to maintain a work pace appropriate to a given work load						X	
Ability to relate to other people beyond giving and receiving instructions						X	
Ability to influence people						X	
Ability to perform complex or varied tasks						X	
Ability to make generalizations, evaluations or decisions without immediate supervisor						X	
Ability to accept and carry out responsibility for direction, control and planning						X	
ENVIRONMENTAL FACTORS							
Works indoors						X	
Works outdoors						X	
Exposure to extreme hot or cold temp						X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
Working at unprotected heights							X
Being around moving machinery						X	
Exposure to marked changes in temperature/humidity						X	
Exposure to dust, fumes, smoke, gases, odors, mists or other irritating particles (aerosol spray from equipment)						X	
Exposure to toxic or caustic chemicals						X	
Exposure to excessive noises							X
Exposure to radiation or electrical energy						X	
Exposure to solvents, grease, or oils						X	
Exposure to slippery or uneven walking surfaces							X
Working in confined spaces						X	
Using computer monitor (keyboard skills)						X	
Working with explosives						X	
Exposure to vibration							X
Exposure to flames or burning items autoclave (excessive heat)						X	
Works alone						X	
Works around others						X	
Works with others						X	
Exposure to Blood and Other Potentially Infectious Materials (OPIM)						X	

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	Never	Sometimes 1-30%	Frequently 31-75%	Always 76-100%	Frequently is per: Day	Job Essential	
						Yes	No
SAFETY EQUIPMENT (REQUIRED TO WEAR)							
Safety glasses						X	
Face mask/face shield						X	
Ear plugs						X	
Hard hat							X
Protective clothing						X	
Protective gloves						X	

If you have any questions or wish to discuss further the essential functions required of this program, please call the Health Occupations Division Office at 414-297-6263.

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MILWAUKEE AREA TECHNICAL COLLEGE
School of Health Sciences
Essential Functions
for the
Medical Assistant Program

_____ I have read and I understand the essential functions for this program.

_____ I have the ability to meet the essential functions as specified.

_____
(Print Name of Program)

_____
(Signed) (Date)

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Students requiring accommodation or special services to meet the essential functions of the program should contact the MATC Student Accommodation Services at any MATC campus.

_____ I require the following accommodations to meet the essential functions as specified and I have provided supporting documentation from my health care provider to the MATC Student Accommodation Services.

_____

_____

_____

_____
(Signed) (Date)

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The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

www.certifiedbackground.com

HEALTH CERTIFICATION

(Print Name and Address)

NAME:_____ **BIRTHDATE:**_____/_____/_____

ADDRESS:_____ **City/State** _____ **Zip Code** _____

PROGRAM NAME:_____ **TELEPHONE #:**_____

Cell Phone #: _____ **E-Mail Address**: _____

STUDENT ID # or SS# :_____

ONLY PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, TO COMPLETE THE FOLLOWING:

I have examined _____ **and certify that she/he is in good physical and mental health.**
Student's Name
On letterhead stationary, please list any physical limitations or other disabilities which would limit this individual's capacity to perform the essential functions of this profession. (See attached)

Physicians, Physician Assistant or Nurse Practitioner SIGNATURE & Medical Title

_____ **Date**_____

Print Professional's Name_____**Office Telephone #**_____

Address_____
Street **City** **State** **Zip Code**

A full exam is on file at _____

IMMUNIZATIONS

Proof of at least two MMR's at least 30 days apart or blood test evidence of rubella and measles immunity. A copy of the titer lab results must be attached if a blood test is performed.

1) MMR _____ _____
Date **Authorized Signature & Medical Title**

2) MMR _____ _____
Date **Authorized Signature & Medical Title**

OR

Rubella Titer _____ _____ _____
Results **Date** **Authorized Signature & Medical Title**

AND

Rubeola Titer _____ _____ _____
Results **Date** **Authorized Signature & Medical Title**

(continue to next page)

The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have a positive blood titer test or documentation of 2 shot vaccinations at least 30 days apart. A copy of the titer lab results must be attached if a blood test is performed.

RESULTS

Has this patient had:

Chicken Pox	_____	_____	_____	_____
	Yes	**No**	**Date**	**Authorized Signature & Medical Title**
OR				
Varicella Vaccine	**#1.** _____			_____
	Date			**Authorized Signature & Medical Title**
30 days laters	**#2.** _____			_____
	Date			**Authorized Signature & Medical Title**
OR				
Varicella Titer	_____	_____		_____
	Date	**Results**		**Authorized Signature & Medical Title**

TWO STEP MANTOUX TUBERCULIN SKIN TEST: Documentation of a Two Step test must be submitted. Skin tests are good for 1 year. If the 2-step is more than a year old, attach documentation of the past 2-step dates, along with a current annual update.

PROCEDURE:

Step 1:

1). A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered under the skin on the forearm.

2). A health care professional must read the results within 48-72 hours.

If negative perform step 2. If positive, must follow- up with a chest x-ray.

Step 2

1). Repeat the test within 7 to 30 days after the application of the first test using the same strength of PPD.

2). A health professional must read the results within 48-72 hours.

If positive, must follow-up with a chest x-ray.

QUANTIFERON – TB GOLD TEST: The TB Gold blood draw may be performed in place of skin tests. TB gold blood draws are good for one year and a copy of the lab report must be attached to the health packet.

REPORTING RESULTS

1. STEP 1 RESULTS

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

2. STEP 2 RESULTS

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

3. ANNUAL UPDATE

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

4. CHEST X-RAY (if required)

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

5. TB Gold Titer

_____	_____	_____	_____
Collection Date	**Date Read**	**Results**	**Authorized Signature and Medical Title**

(continue to next page)

The applicant must: 1). Upload the original completed form to your CertifiedBackground profile.
2). Retain a copy for your records.

PROOF OF TETANUS IMMUNIZATION: (Within the last 10 years)

_____	_____
Date	**Authorized Signature and Medical Title**

PLEASE NOTE: You MUST make a copy of your completed health form and retain it. You may need to provide it to a clinical agency.

DO NOT UPLOAD UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE.

IMPORTANT

I give permission to release information on this health form to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Signature of Student _____

INSTRUCTIONS TO STUDENTS

- **Did your doctor or authorized medical person sign every authorized signature, dates and results of tests?**
- **Is your physical exam completed and all necessary information on the form complete?**
  i.e. (signatures, print name, address, telephone #, lab results, etc.)
- **Do we have your home phone # on the space provided?**
- **Do you have a copy?**

If you have questions about uploading forms please contact Certified Background at 888-666-7788 or email them to
studentservices@certifiedprofile.com

If you have specific health related questions please email Joe Tuttle at tuttlejm@matc.edu or call 414-297-7871

Health Records and Petition Office Reception Desk
414-297-6482
between the hours of
8am. – 4pm
Monday - Friday

(Revised 10/14/11 JMT)

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MILWAUKEE AREA **Technical College**

School of Health Sciences

Information About Hepatitis B Vaccines

THIS GENERAL INFORMATION IS PROVIDED AS A COURTESY AND MATC MAKES NO REPRESENTATION AS TO ITS ACCURACY. YOU SHOULD CONSULT YOUR PHYSICIAN FOR ALL MEDICAL INFORMATION REGARDING THE MATTERS GENERALLY DESCRIBED HERE.

The Disease and the Risks

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely, but approximately 2-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Immunization again Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

Risk of Exposure

Medical and paramedical personnel are at increased risk of contracting hepatitis depending upon their degree of exposure to the blood or body fluids(e.g. saliva, feces, sweat, vaginal secretions, respiratory secretions and other body secretions) of patient infected with Hepatitis B (known or unknown). Hepatitis B is spread by direct contact of broken skin or mucus membranes with the blood or body fluids of a person who has Hepatitis B or is a carrier of the disease. Routine or frequent handling of blood or contaminated tissue products, therefore, constitutes significant risk because of the ease of transmission of the disease and the fact that many people with Hepatitis B have no symptoms and do not know they have the disease.

The first line of defense against Hepatitis B is the Hepatitis B vaccine. Immunization with the Hepatitis B vaccine is the most effective method of preventing HBV infection.

The Vaccine

The Hepatitis B vaccine (Engerix B, Recombivax HB) is produced using recombinant DNA technology. The vaccine works by stimulating the immune system to produce antibodies to the virus.

The vaccine is given intramuscularly in the deltoid in three doses. The second dose one month after the first, and the third dose six- twelve months after the second. After vaccination, more than 90% of healthy adults develop protective antibodies. The cost is about $150.00 for the series. Only minor adverse reactions have been reported with vaccination, including transient fever and soreness at the injection site, rash, nausea joint pain and mild fatigue have also been reported. The vaccine is not contraindicated in pregnancy.

Reference

a. Ganza, a., Torshner, L. (1997) Hepatitis Update. RN, 60 (12), 39-44.

b. Hepatitis B Virus Vaccine Safety: Report of an Interagency Group: MMWR 31(34): 465 September 3, 1982.

c. Hollinger, F. Blaine: Hepatitis B Vaccines-To Switch or Not to Switch. JAMA 257 (19): 2634-2636, May 15, 1987.

d. Inactivated Hepatitis B Virus Vaccine: Annual of Internal Medicine 97:379-83, 1982.

e. Jilg, W., et.a.: Clinical Evaluation of a Recombinant Hepatitis B Vaccine. The Lancet: 1174-1175, November 24, 1984.

f. Krugman, Saul: The Newly Licensed Hepatitis B Vaccine. JAMA 247 (14): 2012-15, April 1992.

g. Leads from the MMWR: Recommendations of the Immunization Practices Advisory Committee Update on Hepatitis B Prevention. JAMA 258(4): 437-449, July 24/31, 1987.

h. Lewis, S., Heitkemper, M., Dirkson, S., (2000). Medical Surgical Nursing. 1193-1198. Mosby.

i. Medical College of Wisconsin, Student Health Services.

Student Name:_____
Name of Program: _____

MILWAUKEE AREA TECHNICAL COLLEGE
Health Sciences Division

RELEASE FORM: HEPATITIS B

Please read thoroughly and check the appropriate box.

☐ I have received and read the information regarding Hepatitis B and the vaccines that are available.

☐ I am declining the Hepatitis B vaccine.

As a student, I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been advised to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can pursue the vaccination series.

I hereby release Milwaukee Area Technical College, its Board Members, and personnel, and any clinical facility at which I train from any liability for any consequences to me or any claims arising out of or related to my decision to be or not to be vaccinated. I hereby agree to indemnify all of the above persons and organizations for any and all claims, including the attorneys' fees and costs, which may be brought against any one of them by anyone claiming to have been injured as a result of any injury which may occur as a result of my decision.

OR

☐ I am currently in the process/or have completed the series. I understand that full immunity requires three doses of vaccine over an eight to 12-month period.

_____ _____
Signature of Student (required) **Date**

IF Hepatitis B vaccine given:

1st Dose Date: _____ _____
Authorized Medical Signature

2nd Dose Date: _____ _____
Authorized Medical Signature

3rd Dose Date: _____ _____
Authorized Medical Signature

Revised: 10/14/11:JMT

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