Maricopa Community Colleges
Allied Health Program Policies for Students

August 2023 through May 2024

Table of Contents

1. General Health Requirements 3
2. Health Declaration 4
3. Immunizations 4
4. BLS/CPR Certification 10
5. Level 1 Finger Print Card 11
6. Statement of Clearance 11
7. Background Checks 11
8. Preclinical Drug Screening 12
9. Medical Marijuana Policy 14
10. "For Cause" Drug Screening Procedure 15
11. Readmission Guidelines Related to Substance Abuse 16
12. Due Process 17
13. Insurance 17
14. Standard Health and Safety Practices 18
15. Accident; Injury; Exposure Guidelines 19
16. Professionalism 19
17. Duty to Report 21
18. Religious Accommodations 21
19. Title IX and Anti-Discrimination 22
20. Forms 24

Academic Allied Health Program Policies

For the protection of students, employees and patients, students enrolled in Maricopa Community Colleges Allied Health Programs (that include assignment to patient care facilities such as hospitals, ambulatory care clinics, skilled nursing facilities and other health care settings) requires that students comply with the following policies, in addition to the policies and procedures in the catalogs and student handbooks

1. General Health Requirements

Students must be able to fully and successfully participate in all program activities whether in the classroom, laboratory or clinical setting. This includes, but is not limited to, the capacity for sensory and motor functions that allow independent classroom/laboratory/clinical performance and routine and emergency client care. It is essential that students in many Allied Health Programs are able to perform a number of physical activities in the clinical portion of their program. For example, students may be required to physically assist and/or lift patients or equipment, stand for several hours at a time and perform bending activities. The clinical experience places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patient lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions. Any student having a temporary medical condition that inhibits or restricts activities must supply a written explanation from their physician. Should a student be unable to participate partially or fully in the program's activities, they may be withdrawn.

A. Should a student require any type of special accommodation, the student must contact the college Disability Resource Center well in advance of the first-class meeting.

B. Should a student require accommodations at a clinical experience, the student must contact the college Disability Resource Center and program manager/director prior to the start of the rotation to coordinate accommodations.

C. Special accommodations for testing will be given only with appropriate documentation to the Disability Resource Center. Individual faculty will not provide or allow extra time, assistive technology, or dictionaries during testing without sufficient documentation in support of an accommodation. It is the responsibility of the student to reach out to DRS to determine eligibility of accommodations.

D. Pregnant students may want to take special precautions due to the physical requirements and possible exposure to harmful diseases or substances. Accommodations will be made if reasonable and possible. In Allied Health Programs where students may be routinely exposed to radiation or any chemicals that may be harmful to an unborn child, the program must inform the student of all precautions and the student must decide of what they wish to do. The law protects the student from suffering any academic penalty due to pregnancy, including the parenting of a newborn.

E. If a student believes that he or she cannot meet one or more of the standards without accommodations, the Allied Health Program must determine, on an individual basis, whether a reasonable accommodation can be made. Students should refer to their respective program policies for required essential skills and functional abilities.

2. Health Declaration

The Health and Safety Documentation form (Exhibit A): must be completed by a licensed/certified healthcare practitioner (M.D., D.O., N.P., P.A.) and submitted according to the time specified by the Allied Health Program. Students should work with their healthcare provider should their health status change during the program.

A. The Program Director may require an updated or additional health declaration should any alteration in the student's health occur.

B. Dental programs may also require proof of completion of a Dental Health Form verifying that the student has completed a dental exam in the last 12 months, and a Vision Exam Form verifying that the student has completed a vision exam and necessary corrections have been completed within the last 6 months.

3. Immunizations

Students must be in compliance with immunization policies of the Allied Health Program in which they are enrolled. The program will provide students with health requirements applicable to that program and the deadline by which students must submit proof of meeting such requirements**. Individuals should consult with their physician regarding necessary and available vaccinations.** Students will be responsible for the cost~~s~~ of completion for all immunization requirements. The following is a description of immunizations that may be required and the type of documentation that a student would have to provide to verify the requirements have been met. (See Exhibit B Health and Safety Documentation) If there is a communicable disease outbreak, additional vaccinations may be required as specified by the local public health agency. Proof of all immunizations and tuberculin skin tests should be copied and submitted to the third-party verification system.

Health and Safety requirements are subject to change without notice depending on clinical agency requirements. If the requirements change due to our agreements with our clinical facilities you will be notified and will be required to meet the changes in requirements

A. COVID-19 Vaccine

As is outlined in Arizona Revised Statutes 15-1650.05, students participating in clinical settings at a healthcare institution licensed under A.R.S. Title 36 which includes hospitals, nursing care institutions, residential care institutions, intermediate care facilities for

individuals with intellectual disabilities (ICF-IID), group homes, or other medical facilities may be required to provide proof of COVID-19 vaccination and subject to regular health screening and testing as determined by the healthcare institutions. (See Arizona Revised Statutes 15-1650.05). Maricopa County Community College District will require all Allied Health and Nursing students to show proof of vaccination in order to ensure compliance with our clinical partner's health and safety requirements.

MCCCD cannot provide accommodation in the clinical setting and cannot force our clinical partners to provide accommodations to students. MCCCD will work with students in an effort to provide clinical experiences necessary for the completion of the program. When necessary, students are required to obtain accommodations from the clinical site by completing the clinical site's religious or medical disability accommodation process if the clinical site has identified a process. If you are unsure if the facility where you have been placed provides accommodations, please visit myClinicalExchange (mCE) to confirm and obtain directions for requesting accommodations from the site.

<u>To meet this requirement:</u>

Upload a copy of proof of COVID-19 vaccine proving vaccination.

1. Provide proof of two-dose vaccination of Pfizer-BioNTech or Moderna vaccine.
OR
2. Provide proof of one dose vaccination of Johnson & Johnson's Janssen vaccine.
OR
3. Provide proof of one dose vaccination of Pfizer-BioNTech OR Moderna Bivalent vaccine.
OR
4. Upload a copy of your signed COVID-19 declination. Please note that a completed declination form does not guarantee clinical placement. Further, the declination notice does not guarantee an accommodation will be granted by a clinical partner or that you will be placed at a clinical site that does not require the COVID-19 vaccine, which may impact your continuation in your clinical course.

Please Note: All documentation is required to have the student's full name, Date of Administration, Manufacturer, and Healthcare Professional or Clinical Site. Annual vaccination and/or renewal are not determined at this time.

B. MMR (Measles/Rubeola, Mumps, & Rubella)

MMR is a combined vaccine that protects against three separate illnesses – measles, mumps and rubella (German measles) – in a single injection. Measles, mumps, and rubella are highly infectious diseases that can have serious, and potentially fatal, complications. The full series of MMR vaccination requires two doses.

If you had all three illnesses OR you have received the vaccinations but have no documented proof, you can have an IgG MMR titer drawn, which provides evidence of immunity to each disease. If the titer results are POSITIVE,

showing immunity to each disease, upload a copy of the lab results.

To meet this requirement:

1. Submit documentation of two MMR vaccinations on separate dates at least 4 weeks apart.

OR

2. Lab documentation of POSITIVE titer results for each disease (measles, mumps and rubella).

OR

3. NEGATIVE or EQUIVOCAL titer results for measles, mumps or rubella shows lack of immunity, meaning you must submit documentation of one MMR booster dated after negative or equivocal titer.

If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have the student's full name and date of immunization administered.

C. Varicella (Chickenpox)

Chickenpox is a highly contagious disease caused by the varicella-zoster virus (VZV). Infection with chickenpox also makes people susceptible to develop herpes zoster (shingles) later in life. The best means of preventing chickenpox is to get the varicella vaccine.

Varicella vaccination is required for all healthcare workers who do not meet evidence of immunity by having met any of the following criteria:

a. Documentation of receiving 2 doses of varicella vaccine, separated by at least 4 weeks **or**
b. Laboratory evidence of immunity or laboratory confirmation of disease. If you haven't had the varicella vaccine or if you don't have a blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.

To meet this requirement:

1. Documentation of two varicella vaccines, including dates of administration.

OR

2. Upload a copy of proof of a POSITIVE IgG titer for varicella. If the titer is NEGATIVE or EQUIVOCAL also upload a booster dose of the vaccination dated after the date of the titer.

If the student has prior immunizations, it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have the student's full name and date of administration.

D. Tetanus/Diphtheria/Pertussis (Tdap):

Tetanus, diphtheria, and pertussis are serious bacterial illnesses which can lead to illness and death. Tdap vaccination can protect against these diseases and is recommended for healthcare personnel with direct patient contact who have not previously received Tdap. Tdap vaccination can protect healthcare personnel against pertussis and help prevent them from spreading it to their patients. The Td vaccine protects against tetanus and diphtheria, but not pertussis.

Following administration of Tdap, a new Tdap should be given if 10 years or more since the initial Tdap.

If you have a Tdap titer, it must include all three components.

Please note- If you submit a non-immune titer for Tdap, you will be required to receive a booster or recommendation from the healthcare provider. Boosters must be dated after your titer.

<u>To meet this requirement:</u>
Provide documentation of a Tdap vaccination administered after the age of 11 and then a Tdap vaccination every 10 years thereafter.

Please Note: All documentation is required to have the student's full name and date of administration.

E. Tuberculosis (TB)

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium.* All students entering a MCCCD Healthcare Program are required to upload documentation showing negative TB disease status. Documentation may include a negative 2-step Tuberculosis Skin Test (TBST) or negative blood test (QuantiFERON or T-Spot) performed within the previous six (6) months. The TBST or negative blood test must remain current throughout the semester of enrollment.

To maintain compliance with annual TB testing requirements, students who initially submitted a 2-step TBST may submit a current 1-step TBST for subsequent annual testing. A TBST is considered current if no more than 365 days have elapsed since the date of administration of the second of the 2-step TBST. Most recent skin testing or blood test must have been completed within the previous six (6) months.

If you have ever had a positive TBST, you must provide documentation of a negative blood test or negative chest X-ray within the last twelve months. You will also need to complete a TB Symptom Screening Questionnaire annually.

This document can be obtained from the program director.

To meet this requirement:

1. Proof of a negative 2-step TBST completed within the previous 6 months, including date given, date read, result, and name and signature of the healthcare provider.

   Follow the steps below:

   Step 1

   1. Administer first TST following proper protocol
   2. Review result

   *Positive - consider TB infected, no second TST needed; evaluate for TB disease (x-ray)

   * Negative - a second TST is needed. Retest in 1 to 3 weeks after first TST result is read.

   3. Document result

   Step 2

   1. Administer second TST 1 to 3 weeks after first test is read
   2. Review results

   * Positive - consider TB infected and evaluate for TB disease (x-ray).

   *Negative - consider person not infected.

   3. Document result

   OR

2. Submit documentation of a negative blood test (QuantiFERON or T- Spot) performed within the last six months.

   OR

3. Submit documentation of a negative chest X-ray if TBST or Blood Testing is positive. The chest x-ray has to be completed within the last twelve months.

4. **POSITIVE RESULTS:** If you currently have, or have had in the past, a positive TBST, provide documentation of negative chest X-ray or negative blood test and a completed MCCCD Healthcare Program Tuberculosis Screening Questionnaire. The questionnaire can be found in the American DataBank Medical Document Tracker. This questionnaire must be completed annually.

If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have the student's full name and date of administration.

F. Hepatitis B

MCCCD Healthcare Program students may be exposed to potentially infectious materials, which can increase their risk of acquiring hepatitis B virus infection, a serious disease that can cause acute or chronic liver disease, which can lead to a serious, lifelong illness. MCCCD Healthcare Programs recommend that all students receive the hepatitis B 3-vaccine series administered over a 6-month period.

Obtain the first vaccination; the second is given 1 - 2 months after the first dose and the third injection is 4 - 6 months after the first dose. Students may also obtain the Heplisav-B 2 dose series administered at least four weeks apart.

Effective immunization status can be proven by a titer confirming the presence of anti-Hbs or HepBSab antibodies in the blood. This titer is recommended but not mandatory.

Please note- if you submit a non-immune titer for Hepatitis B, you will be required to receive a booster or recommendation from your healthcare provider. Boosters must be dated after your titer.

Students may choose to decline the hepatitis B vaccine; however, lack of immunity to hepatitis B means that students remain at risk of acquiring the disease. Any declination must follow the proper protocol for medical or religious accommodation processes.

<u>To meet this requirement:</u>

1. Submit a copy of laboratory documentation of a positive HbsAb titer. Students will be required to receive a booster or recommendation from your healthcare provider that may indicate a booster, series (3 doses of the Hepatitis B vaccine, or 2 doses of the Heplisav-B vaccine), or declination form. 3 Post-Titer Hepatitis B Boosters or 2 Post-Titer Heplisav Boosters dated AFTER your titer.

OR

2. Upload a copy of your immunization record, showing completion of the three Hepatitis B injection or two Heplisav-B injections. If the series is in progress, upload a copy of the immunizations received to date. You must remain on schedule for the remaining immunizations and provide the additional documentation. One to two months after your last immunization, it is recommended that you have an HbsAb titer drawn.

OR

3. Upload a copy of your signed Hepatitis B declination noting that by declining the vaccine you continue to be at risk of acquiring hepatitis B, a serious disease. The Maricopa declination form is available in American DataBank.

If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have the student's full name.

G. Influenza (Flu Vaccine)

Influenza is a serious contagious respiratory disease, which can result in mild to severe illness. Susceptible individuals are at high risk for serious flu complications, which may lead to hospitalization or death.

The single best way to protect against the flu is annual vaccination. A flu vaccine is needed every season because:

a. The body's immune response from vaccination declines over time, so an annual vaccine is needed for optimal protection.
b. Because flu viruses are constantly changing, the formulation of the flu vaccine is reviewed each year and sometimes updated to keep up with changing flu viruses. The seasonal flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season.
c. Students are required to be vaccinated <u>every flu season</u> and to upload documentation proving annual vaccinations.

<u>To meet this requirement:</u>

1. Upload a copy of proof of flu vaccine proving annual vaccination.

   or

2. Upload a copy of your signed Influenza declination noting that by declining the vaccine you continue to be at risk of acquiring the influenza virus.

Please Note: All documentation is required to have the student's full name. Documentation must also contain the following information (Student Name, Facility/Site Name, Date of Administration, and Renewal Date.

4. CPR BLS (Healthcare Provider or Equivalent) Certification

CPR BLS is a procedure performed on persons in cardiac arrest in an effort to maintain blood circulation and to preserve brain function. MCCCD Healthcare Program students are required to learn CPR by completing an acceptable Basic Life Support course.

CPR BLS certification must include infant, child, and adult, 1-and 2-man rescuer, and

evidence of a hands-on skills component. Due to accreditation and clinical partners' requirements, American Heart Association CPR BLS is required to be completed. Please be aware that different areas of study may have other requirements and CPR BLS requirements are subject to change. CPR BLS courses are offered at numerous locations throughout the greater Phoenix area, including MCCCD campuses. The American Heart Association provides in-person courses and a blended learning course. Students who complete online courses must complete the hands-on skills training and testing, as well as the online didactic portion to be eligible to receive a card. CPR BLS training without the hands-on skills training and testing component will not be accepted. Students are required to maintain current CPR BLS certification throughout enrollment in the program.

If utilizing RQI, a third-party vendor for the American Heart Association, it must include the AED component. If you are unsure please contact your program before enrolling into your CPR course.

To meet this requirement:
Upload a copy of the signed CPR card (front and back) or CPR certificate.

5. Level One Fingerprint Clearance Card

All students admitted to any MCCCD Healthcare Program are required to obtain and maintain a valid Level One Arizona Department of Public Safety Fingerprint Clearance Card (FCC). The FCC must remain current throughout every semester in which the student is enrolled in a clinical experience.

If the FCC is suspended or revoked at any time during the program, the student must report this to their Program Director or Program Manager within five (5) school days and the student will be unable to continue in the program until the FCC is reinstated.

To meet this requirement:
Upload a copy (front and back) of a current Level One DPS Fingerprint Clearance Card.

6. Statement of Health Clearance

Must be completed and signed by a licensed healthcare provider (M.D., D.O., N.P., P.A.) within the past six (6) months of start date.

To meet this requirement:
Upload a copy of the signed Statement of Health Clearance completed within the past six (6) months of start date.

7. American DataBank Clearance Document/Background Check

All students admitted to MCCCD Healthcare Program are required to show a "Pass" result on the MCCCD-required supplemental background screening completed within the past six (6) months through American DataBank.

Information regarding the background clearance is obtained from MCCCD Healthcare Program following your acceptance into the program. Please note that results of the American DataBank background check cannot be accessed by the program.

To meet this requirement:
Complete the background check within American Databank and then upload a copy of your American DataBank Pass Certificate showing a passed clearance completed within the previous six (6) months.

IMPORTANT:

1. All students will purchase supplemental background screenings and Medical Document Tracker from American DataBank. Program requirements will be approved by American DataBank.
2. Students are responsible for maintaining all health and safety requirements and to submit documentation by due date. Failure to maintain program health and safety requirements will result in inability to continue clinical experiences and may result in withdrawal from the program.
3. All immunization records must include the student name and the signature of the healthcare provider.
4. Health and safety requirements are subject to change depending on clinical agency requirements.

8. Preclinical Drug Screening

All allied health students are required to submit to a pre-clinical urine drug screen according to policy of the specific Allied Health Program. Students will be expected to follow the guidelines and timeline provided to them by your program. The drug screening will be random and the student will be expected to pay at the time of the order. Private health insurance will not pay for this screening.

A. Students will receive information from the program with steps to place an order with the contracted vendor. The program will identify the time frame the student has to complete the urine drug screening.
B. Once the order is placed the vendor will provide a receipt upon payment.
C. Students will receive a form authorizing the contracted laboratory to perform the test. The authorization form will be needed when performing the test. This form will include the student's name, college name, program designation, program account number. If the form is not taken to the collection site, the student will not be able to complete the urine drug screening, and a new order will be placed at an additional cost.

D. Once the form is provided the student will be responsible for completing the drug screening at the outlined timeline provided by the program.

E. It is important that students understand that they may not take a prescription to the lab to be evaluated during the testing process**.** The laboratory will conduct the urine screening and will immediately provide all negative results to the Allied Health Program Director or designee indicated by the program account number.

F. If a student provides a diluted sample, an additional test must be performed on the sample at an additional cost to the student. Diluted test results will be immediately provided to the Allied Health Program Director or designee.

G. If a student receives a negative dilute, the student will take a second drug screening at their expense. If the student receives a second dilute, the student will remain in the program, and the program will follow the "For Cause" Testing processes if needed.

H. If a student provides a positive sample which MRO indicates may be due to food consumption, the program will verify with American DataBank, the result will remain positive and students will be asked to retest within a designated time frame at the expense of the student.

I. If a student tests positive for substances, the lab will contact the Medical Review Officer (MRO) contracted by the Maricopa Community Colleges. The MRO will contact the student to elicit any prescription drug usage and will subsequently inform the Allied Health Program Director, Program Manager, or designee as to the final results. The Program Director, Program Manager, or designee will receive written notification from the lab that the student is under MRO review. This notification will be made immediately upon the initiation of an MRO review.

J. If the MRO indicates the positive result could be related to food consumption, the student would have 48 to 72 hours to retest at the student's expense. If the second test is positive, we will follow due processes to review removal of the student from the program.

K. For a student to challenge the results that have been MRO reviewed, and released, the student will call the Medical Review Office at 1-321-821-3383. The student will state that a dispute is being requested, and the process will be provided to the student by the MRO staff.
   1. First, a fee of $250.00, credit/debit or check, will be required as paid.
   2. This fee is set up, and structured, by the Medical Review Office, and is not collected for American DataBank.
   3. Once the fee has been paid, the specimen that is being challenged will be shipped to an alternate facility to uphold the integrity of the testing process.
   4. Once testing of the specimen has been completed, the results will be released to the Medical Review Office to be re-reviewed.
   5. Phone interviews will take place as needed.

6. Upon the retest being done, the disputed results will be sent to American DataBank.

L. Please note, even in the event that the results disputed do not change, the report will be released as a new report. This upholds the legal requirements that are provided to the student. This updated report will be reflected in the Complio account as the result of the retest.

M. Final point to know during a drug screen dispute process - the specimen that is tested will not be a new specimen from the applicant. Any dispute must be done by the original specimen that was collected, that provided the result of the report being challenged. Any dispute actions that will be taken by a student are asked to be done promptly in order to be able to completely provide the requested services. If a new collection is being requested from an applicant, that will require a new registration form purchased through their Complio account.

N. If the MRO determines there are safety sensitive issues/concerns related to a student's drug profile further evaluation by a professional will be required and a student may be on temporary exclusion from the program until the evaluation is completed. Students testing positive for drugs that are illegal substances, non-prescribed legal substances, or students deemed unsafe for the clinical setting by the MRO will not be permitted to attend allied health didactic and clinical courses. In the event that a student is withdrawn from classes, the student may invoke their rights under the MCCCD Student Conduct Code. Students who are licensed or certified in a health profession by the State of Arizona and test positive for these drugs will be reported to their respective Boards.

O. Students testing positive and needing an MRO evaluation will be responsible to pay for the cost of the MRO review. In the event a student fails to pay the MRO fee, a financial obligation will be posted to his/her college account

P. Students will **NOT** be allowed to use previous drug screens requested by any person or agency outside the Maricopa Community Colleges to meet these requirements. It is at the Program Directors discretion to accept any drug screening completed from another MCCCD program or campus as long as the student has been continuously enrolled.

Q. Students failing to test during the date and time documented on the Drug Testing Letter do not meet the requirement for drug testing and may be withdrawn from all Allied Health courses. In the event of a withdrawal being made from classes, students may invoke their rights under the MCCCD Student Conduct Code.

9. Medical Marijuana Policy

a. Maricopa Community Colleges prohibit the possession and use of marijuana on all campuses and in all off-campus student activities, including internships and clinical

learning experiences in health programs. This policy is dictated by Arizona Revised Statutes § 15-108, which prohibits any person, including a medical marijuana cardholder or recreational user, from possessing, distributing, or using marijuana on the campus of any public university, college, community college, or post-secondary education institution, regardless of the decriminalization of marijuana in Arizona. Federal legislation prohibits any institution of higher education that receives federal funding from allowing the possession and use of marijuana on campus or at any college/district-related activity or event.

b. Maricopa Community Colleges receives federal funds through grants and federal student aid (financial aid). Maricopa Community Colleges continue to enforce current policies regarding controlled substances and any student or employee who violates university policy prohibiting the use, distribution, or possession of illegal drugs on campus or in student activities—including educational internships—will be subject to disciplinary action and criminal prosecution.

c. Urine drug screens are required of students prior to attending any healthcare courses, including clinical experiences. Medical marijuana, or its metabolite, is not an accepted substance in urine drug screens and will result in a positive urine drug screen. Students with a prescription for medical marijuana would not be considered exempt from urine drug screening.

d. All placements governed by this clinical placement/externship agreement are hereby identified as safety-sensitive positions where the health and safety of the populations served are at issue.

10. "For Cause" Drug Screening Procedure

The information below refers to the use/misuse of, or being under the influence of: alcoholic beverages, illegal drugs or drugs that impair judgment while on duty in any health care facility, school**,** institution or other work location as a representative of an Allied Health Program.

If the clinical instructor/clinical site supervisor perceives the odor of alcohol or observes behaviors such as, but not limited to, slurred speech, unsteady gait, or confusion, and these behaviors cause the faculty or clinical instructor to suspect the student is impaired by alcohol or drugs, the following steps are taken:

a. The instructor will remove the student from the patient care setting or assigned work area and notify the clinical agency supervising personnel.

b. Upon student's verbal consent, the instructor will contact a transportation service and arrange for student transport to a designated medical service facility contracted by Maricopa Community Colleges.

c. The student is to have a picture ID in their possession.

d. After testing, the student may call the transportation service contracted by Maricopa Community Colleges for transport home.

e. If the student admits to alcohol or drug use, a drug screening will still be required.

f. If the results of the test are positive for drugs, alcohol, or other illegal substances, or for non-prescribed legal substances, the student will be responsible for the cost of transportation and testing.

g. If the results of the test(s) are negative for drugs, alcohol, or other illegal substances, or for non-prescribed legal substances, the student shall meet with the Program Director within 24 hours of the test results to discuss the circumstances surrounding the impaired clinical behavior.

h. If the indicator was the odor of alcohol, the student will be mandated to discontinue the use of whatever may have caused the alcohol-like odor before being allowed to return to the clinical setting.

   If the indicator was behavioral, consideration must be given to a possible medical condition being responsible for the symptoms. A medical referral for evaluation may be indicated.

   i. Based on the information provided and further medical evaluations if warranted, the Program Director or Program Manager will make a decision regarding return to the clinical setting.

   ii. If the results of the test(s) are positive for alcohol or other illegal substances or for non- prescribed legal substances, the Program Director or Program Manager will withdraw the student from all clinical courses for a period of one year. The student will be ineligible to enroll in further didactic courses for a period of one year. In the event of a withdrawal being made from classes, students may invoke their rights under the MCCCD Student Conduct Code. The student will pay for all costs associated with the for-cause drug- screening test.

i. If the student with positive results holds a certificate or license in a health profession screening result test will be reported to the applicable Board.

j. If a Student refuses "for Cause" Testing: The instructor will remove the student from the clinical or laboratory/simulation setting pending a full investigation.

   i. The instructor will contact the transportation service contracted by Maricopa Community Colleges to request that the student be transported home.
   ii. Failure to comply with any aspect of this policy will result in withdrawal from the program. In the event there is a withdrawal from classes, the student may invoke their rights under the MCCCD Student Conduct Code.

11. Readmission Guidelines Related to Substance Abuse

Students withdrawn from Allied Health programs for reasons related to

substance abuse will:

1. Submit a letter requesting readmission to the Allied Health Program.

2. Include documentation from a therapist specializing in addiction behaviors indicating status of abuse, addiction, or recovery and/or documented rehabilitation related to the alcohol/drug illness.

3. Include documentation of compliance of a treatment program as identified by the therapist including a statement that the student will be able to function effectively and provide safe and therapeutic care for clients in a clinical setting.

4. Repeat drug screen for alcohol/drugs immediately prior to readmission.

If a student, after being re-admitted to the Allied Health program, has positive results on an alcohol/drug screen, the student will receive permanent dismissal from the Allied Health Program.

12. Due Process

If a student has his/her/their continuation in a class or the academic program called into question based upon a positive drug test, a failed background check, or a code of conduct violation that may prevent the program's ability to place the student at a clinical site, the student will be afforded due process prior to being removed from the class/program.

13. Insurance

Students are strongly advised and may be required by some clinical facilities to carry their own health and accident insurance.

a. Given the potential exposure to communicable disease it is highly recommended that students in Allied Health Programs carry health care insurance at all times while enrolled in the program. Some clinical agencies may require those students who come to that facility for clinical learning experiences have health care insurance**.** Each student is personally liable for any illness or accident during or outside of school activities.

b. While students are participating in any academic or clinical learning experience, they have limited accident coverage by the Student Accident Insurance Policy. They are not covered in any activity outside of school requirements. The cost of this policy is covered in the student activity fee. Program Directors, please refer to the Risk Management website https://maricopa.sharepoint.com/sites/DO/business/rm/Pages/international-education/default.aspx for plan brochure, Claim filing procedures, claim forms, and ID cards. Coverage is subject to change each policy year. Coverage is effective August 1st. Student accident insurance coverage is secondary to the student's primary coverage.

c. If a student is injured or becomes ill during the clinical experience, a Maricopa Community Colleges accident insurance form and verification of other insurance coverage must be completed. Claim forms may be obtained from the Vice President of the Student Affairs Office. Completed forms are submitted to the Allied Health Program Director for signature and then forwarded according to campus procedure.

d. Students are responsible for their own transportation and vehicle insurance to and from the clinical agency.

e. Maricopa Community Colleges provides medical malpractice insurance coverage for students enrolling in Allied Health Programs.

f. All incidents need to be reported to Campus Public Safety. They will fill out a report and forward it to Risk Management.

14. Standard Health and Safety Practices

a. Students are required to follow standard health and safety practices and to complete an Assumption of Risk and Liability form (obtained from Program Director or Program Manager).

b. All blood and body fluids are considered potentially infectious and are treated as if known to be infectious for HIV, HBV, and other blood borne pathogens.

c. Contaminated sharps shall be handled according to their program instruction. Avoid bending needles or using unsafe recapping methods. Shearing or breaking of contaminated needles is prohibited.

d. Contaminated sharps must be placed in an appropriate container as soon as possible.

e. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in the work area where there is a likelihood of occupational exposure.

f. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

g. When exposure is possible, personal protective equipment (PPE) shall be used. Personal protective equipment includes:
    i. Gloves shall be worn when it can be reasonably anticipated that the individual may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin, when performing vascular access procedures, and when touching contaminated items or surfaces.
    ii. Masks, eye protection, and face shields shall be worn whenever splashes, spray, splatter, or droplets of blood or other potentially

infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

iii. Gowns, aprons, and other protective body clothing shall be worn in occupational exposure situations and will depend upon the task and the degree of exposure anticipated.

iv. Surgical caps or hoods and shoe covers shall be worn in instances when gross contamination can be reasonably anticipated.

v. Hands shall be washed immediately after removal of gloves or other personal protective equipment.

(Excerpts from OSHA Blood borne Pathogens Section 1910.1030)

h. When exposure to other hazardous materials such as disinfectant solutions is a possibility, appropriate PPE and safe handling protocols shall be used.

15. Accident; Injury; Exposure Guidelines (Credit & Clock Hour Programs)

When a student is involved in an accident, injury or exposure either on campus or at a clinical setting, specific guidelines have been developed to assist the program and student navigate the process to ensure all procedural steps have been taken and all appropriate parties have been notified. Please refer to pages 42 and 43 for the *MCCCD Healthcare Programs Credit/Clock Hour Accident, Injury, and Exposure Guidelines* and *Student Injury/Exposure Incident Report Form*.

16. Professionalism

Students enrolled in a program of study in Allied Health are responsible for conducting themselves in a professional manner at all times. Some specifics of professional behavior include**:**

a. **Health Insurance Portability and Accountability Act (HIPAA):** all verbal, electronic, and written information relating to patients/clients and contracted agencies is considered confidential and is not to be copied or discussed with anyone or removed from a health care facility unless written permission has been given by the clinical agency to remove such information**.** Information may be disclosed only as defined in HIPAA guidelines for educational purposes. A breach of confidentiality will result in disciplinary action, up to and including possible dismissal from the program and/or course. Refer to the Student Confidentiality Agreement (within Forms section or obtain from Program Director).

b. **Zero Tolerance:** The Maricopa Community College District Allied Health Programs support Zero Tolerance Policy. Any Allied Health Program student engaging in any of the following behaviors or other misconduct is subject to immediate dismissal from Allied Health classes, respecting the student due process and disciplinary action as described in the Student Handbook of the college.

1. Intentionally or recklessly causing physical harm to any person on the

campus or at a clinical site, or intentionally or recklessly causing reasonable apprehension of such harm.

2. Unauthorized use or possession of any weapon or explosive device on the campus or at a clinical site.
3. Unauthorized use, distribution, or possession for purposes of distribution of any controlled substance or illegal drug on the campus or at a clinical site.

c. **Professional staff & client relationship:** students providing allied health services strive to inspire the confidence of clients. Students must treat all clients, health care providers, and staff professionally. Clients can expect those providing Allied Health services to act in their best interests and respect their dignity.

    1. The student should abstain from excessive personal disclosure, obtaining personal gain at the client's expense and refrain from inappropriate involvement in the client's personal relationships.
    2. In a student role, professional boundaries exist among the student, the instructor, the clinical staff, and the client. Students unclear of proper behavior or of an appropriate response to a client should consult the instructor for guidance.

d. **Professional appearance:** proper hygiene and professional appearance are expectations of all Allied Health Programs.

i. Students must dress according to their specific Allied Health Program requirements.

ii. Dress and appearance for the clinical experience are also found in program specific requirements and include but may not be limited to:

    1. Subtle makeup.
    2. Hair pulled back from face and out of the field of operation, in a professional standard style and, if dyed or if extenders are worn, they must be conservative and kept clean.
    3. If worn, beards and mustaches must be neatly trimmed. Some programs may require removal of facial hair should it interfere with the effectiveness of personal protection equipment.
    4. Fingernails must be clean and, if performing patient care, must also be short and neatly trimmed.
    5. <u>Proper hygiene:</u> bathe/shower daily; use deodorant, wear freshly laundered uniforms/lab coats, etc. for each clinical visit. Avoid the use of perfume, cologne, strong smelling body lotion or creams; brush teeth (2x day minimum) and floss daily, and avoid smoking or use of tobacco products.
    6. No body piercing jewelry or tattoos are to be visible or a hindrance to performance in the healthcare setting.

e. **Personal electronic devices:** pagers, cellular telephones and other personal electronic devices (PED) must be turned off and out of sight during lectures, labs and clinical experiences. At no time may students use a PED to take photographs of any patient or any part of a medical record. Any personal electronic device in sight may be confiscated by the instructor and kept until the end of the day's activities. Any use of a personal electronic device during quizzes, tests, exams and other academic activities will be construed as cheating and treated accordingly. Any response to a PED must only be completed during break using the PED or a public telephone.

17. Student's Duty to Report

All students enrolled in Allied Health Programs have the following duty to report:

a. Students holding or receiving certification or licensure in a health profession must remain in good standing with the Board that issues their certification or licensure. Students receiving any disciplinary actions against their certificate and/or license must notify their Program Director within five (5) school days.

b. Any student with an arrest or conviction must notify their Program director within (5) school days.

c. Any student who has their fingerprint card revoked or suspended or modified in any way must notify their Program director within (5) school days.

d. The Program Director reserves the right to dismiss or restrict the student's participation in clinical experiences and involvement in patient care until the certificate/ license or fingerprint card is valid and unrestricted.

18. Religious Accommodations Procedures

a. Definitions

i. Religion or creed: includes traditional, organized religions but also religious beliefs, including those that are new, uncommon, not part of a formal church or sect. All aspects of religious belief and observances that are sincerely held will be considered as part of this policy

a. *Religious Practice or Belief:* A sincerely held practice or observance that includes moral or ethical beliefs as to what is right and wrong, most commonly in the context of the cause, nature and purpose of the universe. Religion includes not only traditional, organized religions, but also religious beliefs that are new, uncommon, not part of a formal religious institution or sect, or only subscribed to by a small number of people. Social, political, or economic philosophies, as well as mere personal preferences, are not considered to be religious beliefs.

ii. Religious Accommodation: A reasonable change in the work or academic environment that enables a student or employee to practice or otherwise observe a sincerely held religious practice or belief without undue hardship

on the college or District.

a. A reasonable religious accommodation may include, but is not limited to:
   1. Time for prayer during a work day,
   2. The ability to attend religious events or observe a religious holiday, or any necessary modification to college or District policy, procedure or other requirement for a student's or employee's (or prospective employee's) religious beliefs, observance or practice, provided such accommodation is reasonable and does not cause undue hardship.

b. Procedures for Seeking Religious Accommodations:

i. All students may request religious accommodation by making a written request for an accommodation to the appropriate faculty member. To the extent possible, requests must be made at least two (2) weeks before the requested absence from class due to religious holiday or day of observance. [Students and employees are encouraged to review the calendar for all holidays/holy days at the beginning of the calendar year (for employees) and semester (for students) and to make accommodation requests as early as possible.]

ii. Faculty members will, upon receiving the request for a religious accommodation, submit the request to the Dean or Academic Chair of their department.

iii. In cooperation with the Dean of Students, or designee, the accommodation request will be reviewed and the student's request responded to within a reasonable time.

iv. a. A reasonable time period should take into consideration the timeliness of the request as well as the imminent nature of the request.

v. Additional information may be necessary, in support of the requested accommodation. In these cases, the additional information should not be overly burdensome and shall not be information more detailed than would be requested for other accommodations (not related to religion).

vi. In situations where an accommodation is not granted, the District Compliance Office must review the reasons for the denial within 72 hours (3 business days) after the denial.

The Religious Accommodation Request form is located at: https://cdn.maricopa.edu/documents/pdf/legal/Religious-Accommodations-Request-Form.pdf

19. Title IX and Anti-Discrimination

A. Title IX

1. Title IX of the Education Amendments of 1972 ("Title IX"), 20 U.S.C. §1681 *et seq.* , is a Federal civil rights law that prohibits discrimination on the basis of sex-including pregnancy and parental status-in educational programs and activities. The policy of the Maricopa County Community College District

(MCCCD) is to provide an educational, employment, and business environment free of sexual violence, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct or communications constituting Sexual Harassment as prohibited by state and federal law. Discrimination under this Policy is an unequal treatment of a student based on the student's actual or perceived gender, sexual orientation, or pregnancy/parenting status. This Policy prohibits Sexual Harassment and Discrimination in any college education program or activity, which means all academic, educational, extracurricular, athletic and other programs.

2. Any person who has experienced, witnessed, or otherwise knows of Sexual Harassment or Discrimination prohibited under this Policy is to report such conduct to the college's Title IX Coordinator. The Title IX Coordinator is trained to help you find the resources you might need, to explain all reporting options, and to respond appropriately to conduct of concern. Such conduct is to be reported to the Title IX Coordinator as soon as possible after it occurs. The Title IX Coordinator tracks all reports of Sexual Harassment or Discrimination.

3. There are several avenues available for any person who experiences, witnesses, or otherwise knows of Sexual Harassment or Discrimination to report such conduct:

    - Leave a private voice message for the Title IX Coordinator;
    - Send a private email to the Title IX Coordinator;
    - Mail a letter to the Title IX Coordinator's office;
    - Visit the Title IX Coordinator (although it is best to make an appointment first to ensure availability);
    - File a Formal Complaint pursuant to this Policy;
    - Report to another trusted college official (e.g., faculty member, coach, advisor) who will provide information as required under the Policy to the Title IX Coordinator.

4. If there is an allegation of conduct in violation of this Policy about the Title IX Coordinator or any staff member who is part of the Vice President of Student Affairs' office, that allegation should be lodged with the President of the college. The President will appoint another trained individual to take the place of the Title IX Coordinator for purposes of the allegation.

5. Title IX Coordinator

The Vice President of Student Affairs serves as each respective college's Title IX Coordinator. The Title IX Coordinator is the individual responsible for providing education and training about Discrimination and Sexual Harassment to the college community and for receiving and investigating allegations of Discrimination and Sexual Harassment in accordance with this Policy. The Title IX Coordinator is authorized to designate other appropriately trained individuals to investigate

Discrimination and Sexual Harassment Complaints and reports as deemed appropriate. The contact information for the Title IX Coordinator at each college may be found at https://district.maricopa.edu/consumer-information/title-ix/title-ix-coordinators.

B. Anti- Discrimination

1. The Maricopa County Community College District is committed to continue to promote a learning and work environment that is non-discriminatory. This commitment is demonstrated through the value of inclusion, the implementation of policies and regulations that serve to prohibit discrimination and by practicing non-discriminatory actions in both our employment and academic activities.

2. This means that Maricopa will not discriminate, nor tolerate discrimination, against any applicant, employee, or student in any of its policies, procedures, or practices.

3. This policy covers all selection and decision practices of the employment relationship, as well as admission to, access to, and treatment of students in Maricopa's programs and activities.

4. The Maricopa County Community Colleges District does not tolerate discrimination in employment or education, against any applicant, employee, or student on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, citizenship status (including document abuse), age, disability, veteran status or genetic information.

20. Forms

The following is a list of forms included in this manual:

Voluntary Assumption of Risk and Release of Liability (p.25)

Consent for Release of Information (p.26)

Compliance with Policies (p.27)

Summary & Acknowledgement of Criminal Background Check (p.28-32)

Patient Privacy and Data Security Agreement-HIPAA (p.33)

Health and Safety Requirements Worksheet (p.34-35)
Clearance for Participation in Clinical Practice (p.36)
Immunization Declination (Hep B, Measles, Mumps, Rubella, Varicella, Diphtheria, Tetanus, Pertussis) (p.37)
Seasonal Influenza Declination (p.38)

COVID-19 Vaccine Declination (p.39)

Accident, Injury, and Exposure Guidelines (p.40-41)

Student Injury/Exposure Incident Report Form (p.42-43)
Report of Significant Exposure to Bodily Fluids or Other Infectious Materials (p.44)

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT ALLIED HEALTH PROGRAMS

Voluntary Assumption of Risk and Release of Liability

[4/2017]

THIS IS A RELEASE OF LEGAL RIGHTS. READ AND UNDERSTAND IT BEFORE SIGNING. Maricopa Community Colleges are non-profit educational institutions. References to Maricopa Community Colleges include its officers, officials, employees, volunteers, students, agents, and assigns. I (print your name)

_____

freely choose to participate in the Maricopa Community College District Allied Health Program. In consideration of my voluntary participation in this Program, I agree as follows:

RISKS INVOLVED IN PROGRAM: I understand that the clinical training environment for the Program in which I am enrolled through Maricopa Community Colleges contains exposures to risks inherent in activities of the Program such as but not limited to: Physical lifting of patients or assisting with movement of patients; Standing for several hours at a time; Bending activities; Contact with communicable and infectious disease; Undertaking of responsibilities and duties impacting patient lives which could cause mental or emotional stress; Property damage: (Specify any potential risks of the individual clinical site)

HEALTH AND SAFETY: I have been advised to consult with a medical doctor regarding my personal medical needs. I state that there are no health-related reasons or problems that preclude or restrict my participation in this Program. I have obtained the required immunizations. I recognize that Maricopa Community Colleges are not obligated to attend to any of my medical or medication needs, and I assume all risk and responsibility therefore. In case of a medical emergency occurring during my participation in this Program, I authorize in advance the representative of Maricopa Community Colleges to secure whatever treatment is necessary, including the administration of anesthetic and surgery. Maricopa Community Colleges may (but is not obligated to) take any actions it considers to be warranted under the circumstances regarding my health and safety. I agree to pay all expenses relating thereto and release Maricopa Community Colleges from any liability for any actions.

ASSUMPTION OF RISK AND RELEASE OF LIABILITY: Knowing the risks described above, and in voluntary consideration of being permitted to participate in the Program, I hereby knowingly assume all risks inherent in this activity and connected activities. I agree to release, indemnify, and defend Maricopa Community Colleges and their officials, officers, employees, agents, and volunteers from and against any and all claims, of whatsoever kind or nature, which I, the participant, my parents or legal guardian or any other person may have for any losses, damages or injuries arising out of or in connection with my participation in this Program.

INDEPENDENT ACTIVITY: I understand that College is not responsible for any loss or damage I may suffer when I am doing Program activities and that College cannot and does not guarantee my personal safety. In addition, I specifically acknowledge that in performing Program activities, I am doing so independently in the status of a student of the Program I choose, and not as an employee or agent of College. I further waive any and all claims which may arise from such Program activities, acknowledge that workers' compensation benefits are not provided to me in my capacity as a student, and hold College harmless from any of my negligent acts. I further state that I am not in any way an employee of College in any capacity. I further agree that I am solely responsible for my own equipment, supplies, personal property, and effects during the course of Program activities.

In addition, I agree that if I drive or provide my own motor vehicle for transportation to, during, or from the Program site I am responsible for my own acts and for safety and security of my own vehicle. I accept full responsibility for the liability of myself and my passengers, and I understand that if I am a passenger in such a private vehicle, College is not in any way responsible for the safety of such transportation and that College's insurance does not cover any damage or injury suffered in the course of traveling in such a vehicle.

SIGNATURE: I indicate that by my signature below that I have read the terms and conditions of participation in this Program and agree to abide by them. I have carefully read this Voluntary Assumption of Risk and Release of Liability and acknowledge that I understand it. No representation, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. This Voluntary Assumption of Risk and Release of Liability shall be governed by the laws of the State of Arizona that shall be the forum for any lawsuits filed under or incident to this Form or to the Program. If any portion of this Form is held invalid, the rest of the document shall continue in full force and effect.

_____ _____

Signature of Program Participant Date

_____ _____

Signature of Parent or Legal Guardian (If student is a minor) Date

Consent for Release of Information [01/2021]

I (print name)_____give permission for the Allied Health faculty and/or Allied Health Director/Chair of the Program in which I am enrolled to share personal information about me including name, **student identification number**, date of birth and verification that the Program has evidence that I have met all the health and safety requirements of the Allied Health Program. This information will be provided to clinical agencies where I am assigned so that I may complete mandated pre-clinical education requirements, obtain entry into the agency's computer system and/or medication administration system, and complete duties necessary in the actual clinical rotations.

This authorization will remain in effect until my Allied Health Program clinical experiences are completed or until revoked. I understand that signing this consent is voluntary, and that revoking the consent prior to a clinical experience may have impact on my ability to be assigned to a clinical agency. A revocation of this consent must be in writing and be delivered to the Director of the Program in which I am enrolled. I also understand that information disclosed under this authorization might be redisclosed by the clinical agency and that such disclosure may no longer be protected by federal or state law.

Disclosure:
In compliance with the federal *Family Educational Rights and Privacy Act of 1974 (FERPA)* a college/university is prohibited from providing certain information from your student records to a third party.

_____ _____
Signature of Program Participant Date

_____ _____
Signature of Parent or Legal Guardian (If student is a minor) Date

Compliance with Policies [01/2021]

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

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

I have received a copy of the Allied Health Programs Policies. I understand this handbook contains information about the guidelines and procedures of the MCCCD Allied Health Program in which I am enrolled. I also understand that I can find information about the general college policies in the College Catalog and the College Student Handbook. I can find information specific to each Allied Health Program from the Program Director and each course in the course syllabus.

_____(initial) I have read and understand that issues such as a positive drug test, a failed background check, or a code of conduct violation may prohibit me from being placed in a clinical site, which places my continuation in a class or in my academic program in jeopardy.

_____(initial) I understand that challenging a positive drug test or a failed background check is done through the vendor contracted to perform such test/check and not with Maricopa County Community College District or its associated colleges and my appeal must be made through the vendor's established process and at my expense. In addition, I acknowledge that the full report from the Medical Review Officer will be provided to the Program Director or designee.

_____(initial) I understand that I will be afforded due process prior to being removed from a class or my academic program due to a positive drug test, a failed background check, or a code of conduct violation. I further understand my participation in this process is vital.

_____(initial) I understand that I may be afforded conditional continuation in my class or academic program pending the outcome of the appeal with the vendor (for a positive drug test or failed background check) and the results of my due process meeting with the college administration. This continuation is conditional, pending the outcome of the appeal(s) and due process meeting.

By signing this agreement, I certify that I have read and understood the Allied Health Programs Policies and will comply with them.

_____ _____

Signature of Program Participant Date

_____ _____

Signature of Parent or Legal Guardian (If student is a minor) Date

_____ _____

Signature name Date

Allied Health and Nursing Programs Maricopa County Community College District

Summary of Criminal Background Check Requirements effective September 1, 2011

Overview of the Requirements

In order for students to be admitted to or maintain enrollment in good standing in Maricopa County Community College District's ("MCCCD") Allied Health and/or Nursing programs ("Programs") effective September 1, 2011, students must include with their application to any healthcare program all of the following:

- A copy of an Arizona Department of Public Safety Level-One Fingerprint Clearance Card ("Card"). Students are required to pay the cost of applying for this card. Cards that are NOT Level-One status will not be accepted.
- An original version of the "Criminal Background Check Disclosure Acknowledgement" form attached to this Summary signed by the student.

Once a student has been offered placement in a nursing or allied health program they will be given information on how to complete the MCCCD supplemental background check with MCCCD's authorized vendor, American DataBank To enter the program the student must be able to provide documentation demonstrating that the student has achieved a "Pass" status on this MCCCD supplemental background check. Students are required to pay the cost of obtaining the background check. Students whose background checks on the date of actual admission to a Program are more than 6 months old or students who have been in a Program for more than 12 months may be requested to obtain an updated background check. This criminal background check is required because many of MCCCD's largest clinical experience partners have established standards that are more stringent than those for obtaining a Level-One Fingerprint Clearance Card.

At all times during enrollment in a Program, students must obtain <u>and</u> maintain BOTH a valid Level-One Fingerprint Clearance Card and a passing result on the supplemental background check performed by MCCCD authorized vendor. Admission requirements related to background checks are subject to change as mandated by clinical experience partners.

Implementation of the Requirements

1. Students who are denied issuance of a Level-One Fingerprint Clearance Card may be eligible for a good cause exception through the Arizona Department of Public Safety. It is the student's responsibility to seek that exception directly with DPS. Until the student obtains said card and meets the other requirements for admission, he or she will not be admitted to a Program.
2. Students admitted to a Program whose Card is revoked or suspended must notify the Program Director immediately and the student will be removed from the Program in which they have been admitted or are enrolled. Any refund of funds would be made per MCCCD policy.

The **Criminal Background Check Disclosure Acknowledgement** directs students to disclose on the data collection form of the MCCCD authorized background check vendor all of the requested information as well as any information that the background check may discover. Honesty is important as it demonstrates character. Lack of honesty will be the basis for denial of admission or removal from a Program if information that should have been disclosed but was not would have

resulted in denial of admission. Failure to disclose other types of information constitutes a violation of the Student Code of Conduct and may be subject to sanctions under that Code.

Students have a duty to update the information requested on the [background check vendor] data collection form promptly during enrollment in a Program. The American DataBank data collection form may ask for the following information but the form may change from time to time:

- Legal Name
- Maiden Name
- Other names used
- Social Security Number
- Date of Birth
- Arrests, charges or convictions of any criminal offenses, even if dismissed or expunged, including dates and details.
- Pending criminal charges that have been filed against you including dates and details. Participation in a first offender, deferred adjudication or pretrial diversion or other probation program or arrangement where judgment or conviction has been withheld.

The authorized MCCCD background check vendor will be asked to pass or fail each student based on the standards MCCCD's clinical experience partners have established as the most stringent requirements. The sole recourse of any student who fails the background check and believes that failure may have been in error is with the background check vendor and not with MCCCD or the individual college

Acknowledgement of Criminal Background Check Requirements Applicable to Students Seeking Admission to MCCCD Allied Health or Nursing Programs On or After September 1, 2011

In applying for admission to a Nursing or Allied Health program ("Program") within the Maricopa County Community College District , you are required to disclose on the Arizona Department of Public Safety (DPS) form all required information and on the MCCCD authorized background check vendor data collection form any arrests, convictions, or charges (even if the arrest, conviction or charge has been dismissed or expunged), or participation in first offender, deferred adjudication, pretrial diversion or other probation program on this form. Additionally, you must disclose anything that is likely to be discovered in the MCCCD supplemental background check which will be conducted.

Students should complete the DPS form, the MCCCD authorized background check vendor form, and any clinical agency background check form honestly and completely. This means that your answers must be truthful, accurate, and complete.

By signing this acknowledgment form, you acknowledge the following:

1. I understand that I must submit to and pay any costs required to obtain a Level-One Fingerprint Clearance Card and an MCCCD supplemental criminal background check.
2. I understand that failure to obtain a Level-One Fingerprint Clearance Card will result in a denial of admission to a Program or removal from a Program if I have been conditionally admitted.
3. I understand that I must submit to and pay any costs required to obtain an MCCCD supplemental background check.
4. I understand that failure to obtain a "pass" as a result of the MCCCD supplemental criminal background check will result in a denial of admission to a Program or removal from it if I have been conditionally admitted.
5. I understand that if my Level-One Fingerprint Clearance Card is revoked or suspended at any time during the admission process or my enrollment in a Program, I am responsible for notifying the Program Director immediately and that I will be removed from the Program.
6. I understand that any clinical agency may require an additional criminal background check to screen for barrier offenses other than those required by MCCCD, as well as a drug screening. I understand that I am required to pay for any and all criminal background checks and drug screens required by any clinical agency to which I am assigned.
7. I understand that the both the MCCCD supplemental or the clinical agency background check may include but are not limited to the following:
   - Nationwide Federal Healthcare Fraud and Abuse Databases
   - Social Security Verification
   - Residency History
   - Arizona Statewide Criminal Records
   - Nationwide Criminal Database
   - Nationwide Sexual Offender Registry

• Homeland Security Search

8. By virtue of the MCCCD supplemental background check, I understand that I will be disqualified for admission or continued enrollment in a Program based on my criminal offenses, the inability to verify my Social Security number, or my being listed in an exclusionary database of a Federal Agency. The criminal offenses for disqualification may include but are not limited to any or all of the following:
   - Social Security Search – Social Security number does not belong to applicant
   - Any inclusion on any registered sex offender database
   - Any inclusion on any of the Federal exclusion lists or Homeland Security watch list
   - Any conviction of Felony no matter what the age of the conviction
   - Any warrant any state
   - Any misdemeanor conviction for any of the following regardless of the age of the crime
     - violent crimes
     - sex crime of any kind including non consensual sexual crimes and sexual assault
     - murder, attempted murder
     - abduction
     - assault
     - robbery
     - arson
     - extortion
     - burglary
     - pandering
     - any crime against minors, children, vulnerable adults including abuse, neglect, exploitation
     - any abuse or neglect
     - any fraud
     - illegal drugs
     - aggravated DUI
   - Any misdemeanor controlled substance conviction last 7 years
   - Any misdemeanor drug paraphernalia conviction in the last 7 years
   - Any other misdemeanor convictions within last 3 years
   - Exceptions: Any misdemeanor traffic (DUI is not considered Traffic)
9. I understand that I must disclose on all background check data collection forms (DPS, MCCCD background check vendor and any clinical agency background check vendor) all required information including any arrests, convictions, or charges (even if the arrest, conviction or charge has been dismissed or expunged), or participation in first offender, deferred

   adjudication, pretrial diversion or other probation program. That includes any misdemeanors or felonies in Arizona, any other State, or other jurisdiction. I also understand that I must disclose any other relevant information on the forms. I further understand that non-disclosure of relevant information on the forms that would have resulted in failing the background check will result in denial of admission to or removal from a Program. Finally, I understand that my failure to disclose other types of information of the forms will result in a violation of the Student Code of Conduct and may be subject to sanctions under that Code.

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

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

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT
2411 West 14th Street, Tempe, AZ 85281 -6942

PATIENT PRIVACY AND DATA SECURITY AGREEMENT

for MCCCD Allied Health and Nursing Programs Clinical Training

Name (Print):_____**College:** _____

The discussions, uses, and disclosures addressed by this agreement mean any written, verbal, or electronic communications.

I understand that I am never to discuss or review any information regarding a patient at a clinical site unless the discussion or review is part of my educational program. I understand that I am obligated to know and adhere to the privacy and data security policies and procedures of any clinical site to which I am assigned. I acknowledge that health records, accounting information, patient information, and conversations between or among healthcare professionals about patients are confidential under law and this agreement.

I understand that, while in the clinical setting, I may not disclose any information about a patient during the clinical portion of my assignment to anyone other than the site's designated health care professionals.

I understand that I may not remove any original health record from the clinical site. I further understand that I may not remove any copy, in part or in total, of the health record without prior written authorization of the clinical site. Additionally, I understand that, before I use or disclose patient information in a learning experience, classroom, case presentation, class assignment, or research, I must exclude as much of the following information as possible:

- Names of the patient or the patient's relatives, employers, or household members
- Geographical subdivisions smaller than a state
- Dates of birth, admission, discharge, and death
- Telephone numbers
- Fax numbers
- E-mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers
- Device identifiers
- Web locators (URLs)
- Internet protocol addresses
- Biometric identifiers
- Full face photographs
- Any other unique identifying number, characteristic, or code
- All ages over 89 years

Additionally, I acknowledge that any patient information may only be used or disclosed for health care training and educational purposes at MCCCD, and must otherwise remain confidential.
I understand that I must promptly report any violation of the clinical site's privacy policies and procedures, applicable law, or this confidentiality agreement, by me, or an MCCCD student or faculty member to the appropriate MCCCD program clinical coordinator or program director.
Finally, I understand that, if I violate the privacy policies and procedures of the clinical site, applicable law, or this agreement, I will be subject to disciplinary action.
By signing this agreement, I certify that I have read and understand its terms, and will comply with them.

Signed:_____**Date:** _____

Health and Safety Requirements Worksheet

Name:_____**Date**:_____

Use this worksheet as a guide to ensure that you have documentation of each requirement. **DO NOT upload this document into American DataBank or MyClinical Exchange.** Only supporting documents (lab results, immunization records, signed healthcare provider form, etc.) for each requirement should be uploaded. Additional information regarding acceptable documentation for each requirement can be found on the American DataBank website.

☐ **MMR (Measles/Rubeola, Mumps and Rubella)** To meet requirement:

1. MMR vaccination: Dates: #1_____ #2_____

OR

2. Date & titer results:

Booster:_____

Measles:_____

Mumps:_____

Rubella: _____ _____

☐ **Varicella (Chickenpox)** To meet requirement:

1. Varicella vaccination dates: #1_____ #2_____

OR

2. Date & results of varicella IgG titer: Date: Result:_____, Booster:_____

☐ **COVID**

Pfizer or Moderna

1. Dose 1: _____
2. Dose 2: _____

OR

Johnson and Johnson

1. Dose 1: _____

OR

Pfizer or Moderna Bivalent

1. Dose 1:_____

☐ **Tetanus/Diphtheria/Pertussis (Tdap)** To meet requirement: Tdap vaccine: Date: ___

Td booster: Date: _____

☐ **Tuberculosis** To meet requirement:

1. Negative 2-step TB Skin Test (TBST), including date of administration, date read, result, and name and signature of healthcare provider.

Initial Test (#1) Date: _____ Boosted Test (#2) Date: _____ Date Read: _____

Results: Negative or Positive

Date Read: _____

Results: Negative or Positive

2. Annual 1-step TBST (accepted only from continuing students who have submitted initial 2-step TBST)

Date: _____ Date Read: _____ Results: Negative or Positive

OR

3. Negative blood test (Either QuantiFERON or TSpot)

QuantiFERON Date: _____

T-Spot Date:_____

OR

4. Negative chest X-ray

OR

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

Date: _____

☐ **Hepatitis B** To meet requirement:

1. Positive HbsAb titer Date: _____ Result: _____

OR

1. Proof of 2 Hepatitis B vaccinations

Hepatitis B vaccine/dates: #1_____#2_____

OR

2.

3. Proof of 3 Hepatitis B vaccinations

Hepatitis B vaccine/dates: #1_____#2 #3_____

_____

OR

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

☐ **Flu Vaccine** To meet requirement:

Documentation of current annual flu vaccine Date: _____

☐ **CPR (Healthcare Provider or Equivalent) Certification** To meet requirement:

CPR card or certificate showing date card issued:_____Expiration date: _____

☐ **Level One Fingerprint Clearance Card (FCC)** To meet requirement:

Level One FCC including date card issued:_____Expiration date: _____

☐ **Health Care Provider Signature Form** To meet requirement:

Healthcare Provider Signature Form signed and dated by healthcare provider. Date of exam: _____

☐ **American Databank Background Clearance Document** To meet requirement:

American DataBank background check document with date of "Pass" status: _____

Allied Health Student Health and Safety Documentation Checklist

Clearance for Participation in Clinical Practice

It is essential that allied health students be able to perform a number of physical activities in the clinical portion of their programs. At a minimum, students will be required to lift patients and/or equipment, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement their assigned responsibilities. The clinical allied health experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions. This declaration should not impede students with disabilities from applying or being accepted into the program.

I believe the applicant (print name):_____Date: _____

_____WILL OR_____WILL NOT be able to function as an allied health student as described above.

If not, explain: _____

_____

_____

Licensed Healthcare Provider (MD, DO, NP, or PA) Verification of Health and Safety

Print Name:_____Title: _____

Signature:_____Date: _____

Address: _____

City:_____State: _____

Telephone: _____

Student Name:_____ Semester: _____

Program: _____ Student ID: _____

I am requesting an exemption from the following vaccinations (mark all that apply):

_____Hepatitis B
_____ Measles
_____Mumps
_____Rubella
_____Varicella
_____Diphtheria
_____Tetanus
_____Pertussis

Immunization Declination:
I decline the selected vaccine(s) due to religious beliefs and/or medical contraindications as indicated by my initials below.

I understand and agree that

1. Signing the declination form does not guarantee clinical placement.

2. A new declination form will be required to be submitted each semester.

3. Clinical experiences may occur during each semester of the program; refer to your program of study.

4. MCCCD will reasonably attempt to place all students in a clinical experience. There is no guarantee that there will be clinical placement opportunities available that will accommodate my vaccination declinations as I move forward in the program. I further understand that MCCCD may not be able to place me in any clinical rotation due to this declination, which could extend the timeline or otherwise affect my ability to complete the program.

5. Signing this declination form does not guarantee that I will receive a vaccination exemption or related accommodation from any clinical partner. I acknowledge that MCCCD cannot require clinical partners to grant exemptions or provide related accommodations to students, nor can it dictate the specific exemption-related accommodations (if any) a clinical partner provides.

6. I must abide by the clinical partner's policies and procedures regarding exemption requests and related accommodations, and I understand that I am responsible for ensuring compliance with any additional precautions imposed by the assigned clinical partners.

MARICOPA COMMUNITY COLLEGES

2023-2024 SEASONAL INFLUENZA DECLINATION

Student Name _____ Semester _____

Program _____ Student ID _____

Immunization Declination:

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

I understand and agree that

1. Signing the declination form does not guarantee clinical placement.
2. A new declination form will be required to be submitted each semester.
3. Clinical experiences may occur during each semester of the program; refer to your program of study.
4. MCCCD will reasonably attempt to place all students in a clinical experience. There is no guarantee that there will be clinical placement opportunities available that will accommodate my vaccination declinations as I move forward in the program. I further understand that MCCCD may not be able to place me in any clinical rotation due to this declination, which could extend the timeline or otherwise affect my ability to complete the program.
5. Signing this declination form does not guarantee that I will receive a vaccination exemption or related accommodation from any clinical partner. I acknowledge that MCCCD cannot require clinical partners to grant exemptions or provide related accommodations to students, nor can it dictate the specific exemption-related accommodations (if any) a clinical partner provides.
6. I must abide by the clinical partner's policies and procedures regarding exemption requests and related accommodations, and I understand that I am responsible for ensuring compliance with any additional precautions imposed by the assigned clinical partners.
7. I may be required to provide additional supporting documentation to MCCCD and/or its clinical partners in conjunction with any vaccination exemption or related accommodation request.

_____ Declination of Seasonal Influenza Immunization due to a sincerely held religious belief.

_____ Declination of Seasonal Influenza immunization due to medical contraindication(s)

Signature _____ Date _____

MARICOPA COMMUNITY COLLEGES

COVID-19 Vaccine DECLINATION

Student Name _____ Semester _____

Program _____ Student ID _____

Immunization Declination:

I decline the COVID-19 vaccine due to religious beliefs and/or ADA/medical contraindications as indicated by my initials below.

I understand and agree that

1. Signing the declination form does not guarantee clinical placement.
2. A new declination form will be required to be submitted each semester.
3. Clinical experiences may occur during each semester of the program; refer to your program of study.
4. MCCCD will reasonably attempt to place all students in a clinical experience. There is no guarantee that there will be clinical placement opportunities available that will accommodate my vaccination declinations as I move forward in the program. I further understand that MCCCD may not be able to place me in any clinical rotation due to this declination, which could extend the timeline or otherwise affect my ability to complete the program.
5. Signing this declination form does not guarantee that I will receive a vaccination exemption or related accommodation from any clinical partner. I acknowledge that MCCCD cannot require clinical partners to grant exemptions or provide related accommodations to students, nor can it dictate the specific exemption-related accommodations (if any) a clinical partner provides.
6. I must abide by the clinical partner's policies and procedures regarding exemption requests and related accommodations, and I understand that I am responsible for ensuring compliance with any additional precautions imposed by the assigned clinical partners.
7. I may be required to provide additional supporting documentation to MCCCD and/or its clinical partners in conjunction with any vaccination exemption or related accommodation request.

_____Declination of COVID-19 Immunization due to a sincerely held religious belief

_____Declination of COVID-19 immunization due to medical contraindication(s)

Signature _____ Date _____

Maricopa County Community College has reviewed and attests the student has provided the declination.

Program Representative Signature _____ Date _____

Program Representative Printed Name _____ Title _____

MARICOPA COMMUNITY COLLEGES

MCCCD Healthcare Programs Credit/Clock Hour Accident, Injury, and Exposure Guidelines

Instructions:
Below are the six steps to complete when a student is involved in an accident, injury or exposure either on campus or at a clinical setting. This document should be used in conjunction with the MCCCD Student Injury/Exposure Incident Report Form to ensure all procedural steps have been taken and all appropriate parties have been notified.

Students, Instructors, and/or Program Directors should also refer to MCCCD Student Accident Insurance Plan website and/or Allied Health, Nursing, or Dental Policies and Procedures Manual.

STEP 1	**INSTRUCTIONS:** Immediately: Student reports the incident to the clinical site preceptor/ supervisor. If the student is on campus, they should report the incident to the instructor.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES: Student should follow the clinical site process and not delay treatment or medical attention if at a clinical site. While on campus, students will follow MCCCD reporting process.			
STEP 2	**INSTRUCTIONS:** Immediately: Student is informed to seek medical triage and treatment.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES: Student is informed they are responsible for all costs related to exposure, triage, and treatment. Treatment must be rendered within 120 days from the incident date for benefits to be considered but may be shorter depending on the type of exposure. Student must refer to the Student/Injury Exposure Incident Report Form for specific timelines for testing following an exposure. Should the student refuse medical treatment, testing, or triage, the student will need to sign the declination of care on the MCCCD Student/Injury Exposure Incident Report Form.			
STEP 3	**INSTRUCTIONS:** Student reports the incident to Program Instructor and/or Director within 24 hours.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES: MCCCD Instructor or Program Director will direct the student to the MCCCD Student/Injury Exposure Incident Report Form.			
STEP 4	**INSTRUCTIONS:** Student downloads and completes the MCCCD Student Injury/Exposure Incident Report Form.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES:			

	MCCCD Instructor or Program Director will assist the student in completing the MCCCD Student/Injury Exposure Incident Report Form as needed. MCCCD Instructor or Program Director will retain a copy of the report for the student file and the student will be provided a copy as well. For insurance and claims processes, refer to the MCCCD Student Accident Insurance Plan for the current academic year.			
STEP 5	**INSTRUCTIONS:** Instructor or Program Director follows up with all parties to ensure the reporting processes have been completed.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES: If the incident occurred at the clinical site, the Instructor or Program Director should follow-up with the Clinical Preceptor or supervisor.			
STEP 6	**INSTRUCTIONS:** Instructor/Program Director conducts a follow up with the student every 30 days (up to 120 days) to ensure we are providing the appropriate level of support to the student while in their academic program.	**DATE COMPLETED**	**TIME COMPLETED**	**INITIALS**
	IMPORTANT NOTES: Identify if the student is progressing in the submission of forms and documents if they need any college level resources such as DRS, Financial Aid, Veterans Affairs, Admissions and Records, Advising, and Tutoring. Instructor/Program Director should not be discussing medical care or treatments and should make every effort to maintain strict confidence.			

STUDENT INJURY/EXPOSURE INCIDENT REPORT FORM

MARICOPA COMMUNITY COLLEGES

Privacy Notice: The information on this form together with any attachments is the property of Maricopa County Community Colleges. State Law requires that you be informed that you are entitled to: (1) request notification of the information collected about you by use of this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge to you.

Instructions: Complete this form within 24 hours of any incident involving injury to a student or exposure of a student to an infectious or contagious disease in conjunction with their coursework. **DO NOT LIST INFORMATION REGARDING A SOURCE PATIENT FOR A BBP EXPOSURE.**

STUDENT	**Name**	**Email Address**	**Phone**
	Address		**MEID**
COURSE OF STUDY		**COLLEGE**	
TIME & PLACE	**Date/Time of incident**	**Location: Street, City, Building, Room No. (Be specific)**	
	◯ AM ◯ PM		

LOCATION OF INCIDENT

Type of Premise			**Conditions**
☐ Clinical	☐ Stairway	☐ Lobby/Entrance	☐ Dry
☐ Classroom	☐ Clinical @Patient's Residence	☐ Parking Lot	☐ Wet
☐ Hallway	☐ Community Health Event	☐ Sidewalk	☐ Icy
☐ Office	☐ Experiential Site	☐ Street	☐ Uneven surface
☐ Lab	☐ Other Location:		☐ Other:

INCIDENT DESCRIPTION

Describe What Happened & If at Clinical/Experiential site include process steps taken ***(Use addt'l sheet if needed)*****:**

DESCRIPTION OF INJURY

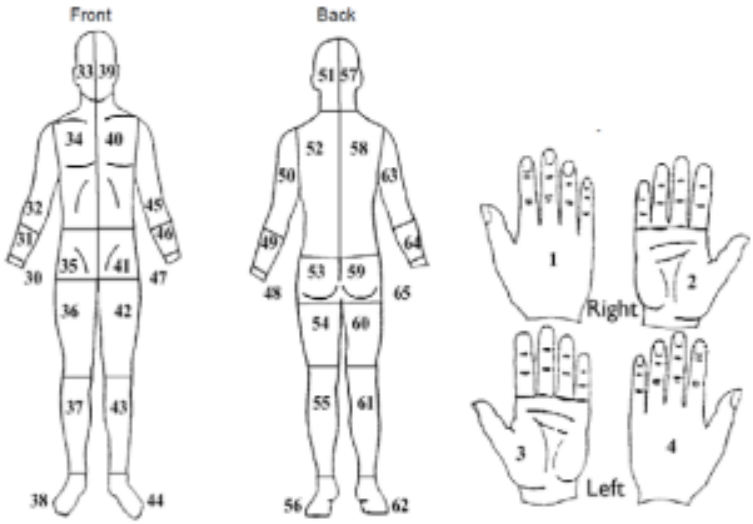
Injury - ***Describe the type, severity, and body part involved***

Was First Aid Given?	◯ Yes ◯ No	**Will seek treatment later?**	◯ Yes ◯ No	**Transported for Care?**	◯ Yes ◯ No

DETAIL OF INJURY

MARK AFFECTED AREAS WITH X

Body Part	L	R	Body Part	L	R
Head			Arm		
Face			Wrist		
Neck			Thigh		
Chest			Knee		
Back			Calf		
Groin			Foot		
Buttock/Hip			Toe		
Hand Part	**L**	**R**	**Finger**	**L**	**R**
Palm			Thumb		
Dorsum			Index/First		
Thumb base			Middle/Second		
Heel of Hand			Ring/Third		
Other			Pinky/Fourth		



DETAIL OF INCIDENT	MARK ALL THAT APPLY Item marked with an asterisk (*) require completion of a Contaminated Sharps Report Form		
	☐ Exposure to communicable disease **Source known**	☐ Face/Head/Eye Injury	☐ Slip/Trip/Fall
	☐ Exposure to Communicable disease **Source unknown**	☐ Rash/Allergic Reaction	☐ Fracture
	☐ Human blood/body fluid exposure (Splash/spray into eyes, nose, mouth skin)	☐ Burn (chemical/thermal/radiation)	☐ Sprain/Strain
	☐ Human blood/body fluid exposure * (Needle stick/sharps exposure)	☐ Abrasion/Contusion/Bruise	☐ Crush injury
	☐ Sharps Injury – uncontaminated sharp	☐ Other:	

COURSE INSTRUCTOR OR SUPERVISOR FOR STUDENT	Name	Email Address	Phone No.
	Address		HAS THIS PERSON BEEN NOTIFIED?
			◯ Yes ◯ No

WITNESSES	Name	Email Address	Phone No.
	1.		
	2.		
	3.		

REPORTED BY	Name	Email Address	Phone No.
	Title	Department	Date

CLINICAL NAME & ADDRESS	

DID YOU SEEK TREATMENT?	◯ Yes ◯ No	DETAILS	
DID YOU REFUSE TREATMENT?	◯ Yes ◯ No	DETAILS	

INSTRUCTIONS FOR COMPLETION OF INJURY/EXPOSURE INCIDENT REPORT

THIS FORM SHOULD BE COMPLETED BY THE INJURED STUDENT.

- BE DETAILED – DOCUMENT AS MUCH INFORMATION AS POSSIBLE ABOUT THE FACILITY, ENVIRONMENT CIRCUMSTANCE OF THE INCIDENT AT THE TIME OF THE REPORT, INCLUDING ANY WITNESSES' CONTACT INFORMATION.

ONLY LIST INFORMATION REGARDING A SOURCE PATIENT FOR A BBP EXPOSURE ON PAGE 3 OF THIS FORM.

DO NOT DISCUSS THE ACCIDENT WITH ANYONE - EXCEPT A RESPONDING INSTRUCTOR OR CLINICAL PRECEPTOR OR COLLEGE POLICE (POLICE ONLY IF THE INCIDENT OCCURRED ON CAMPUS PROPERTY).

Declination Statement

I understand that due to my exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B, Hepatitis C or HIV infection. I am aware of the risks of not seeking post-exposure testing and prophylactic treatment; however, I decline decline these measures at this time. I understand that by declining, I continue to be at risk of acquiring these blood borne diseases.

Student Signature: _____ Date: _____

REPORT OF SIGNIFICANT EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is NOT a claim form; but ONLY a report of exposure).

1. Exposed Student _____ Birth Date _____ Curriculum _____
   Last Name First M.I.
2. Address _____ Phone No. _____
3. Employer's Full Name _____
4. Employer's Address _____
5. Date of Exposure _____ Time of Exposure _____
6. Address or Location of Exposure _____
7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific)
8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.
   - ☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe)
   - ☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions Other (specify):
   - ☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)
9. Source person(s) information ◯Unknown ◯Known
   Name _____ DOB _____ Phone No. _____
   Address _____ City _____ State _____ Zip _____
10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)?
11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)?

I HAVE GIVEN THIS FORM TO MY INSTRUCTOR AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

STUDENT SIGNATURE _____ DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C

1. **You must file this report with your Instructor no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure. (Baseline testing)**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**

Other Required Steps to Establish Prima Facie Claim for MRSA

1. **You must file this report with your Instructor no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your**
3. **Instructor the details of the exposure.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB

1. **You must file this report with your Instructor no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**

Clear Form

Instructor: Keep Original Student: Keep Copy