KLAMATH Community College

Phlebotomy

Application & Registration Form

541.880.2243|ce@klamathcc.edu

Course Description:

Phlebotomy is the practice of drawing blood from patients and taking the blood specimens to the laboratory to prepare for testing. During this course, you will be shown how to draw blood, known as a venipuncture. You will practice your venipuncture skills in the classroom on fellow students so you are prepared and confident before you begin your internship.

This course will be 10 weeks long, with 9 hours of classroom instruction per week as well as a 40-hour internship with a local provider to practice phlebotomy on real patients. Participation and attendance are mandatory to be placed in an internship and to take the national certification exam. At the end of the course, students will be eligible to take the NHA (National Healthcare Careers) Phlebotomy certification exam to become a certified phlebotomist.

This course has a student cap of 15 students. Students will be entered into the program on a first come, first serve basis. 1/3 of course tuition is due at registration and fees must be paid in full prior to testing for certification. Payment plans are available. Inquire with cashier in Building 9.

Program requirements:

- High school graduate or GED equivalent
- Up to date on all vaccinations
- 40 hour internship
- BLS American Heart Association card (done in class)
- Bloodborne Pathogens training (done in class)
- Must be 18 years or older before class starts.
- Hepatitis B vaccine series &Tuberculin (TB) skin test
- Drug Screen (CastleBranch)
- Background Check (CastleBranch)

Requirements to be completed during course:

•Completion of agreement & internship orientation with clinic prior to internship
(Students will not be eligible to sit for national exam until a 40-hour internship is completed)
•Completed orientation packet and signed Confidentiality Agreement form submitted to Human Resources at Sky Lakes Medical Center 30 days prior to internship start date (these will be provided in class)
•Start online application for Phlebotomy Certification on NHA website
•Schedule time and date to take Exam (cost of exam is included in the cost of the program if the student takes the exam within 6 months of completing the course)
•Pass a random drug screen and background check (No refunds due to inability to pass background check/drug screen)
•Screening can be conducted any time prior to the start of internship. All applicants understand that inability to pass the drug screen and/or background check will affect their ability to complete internship and program requirements.

*Disclaimer: Although marijuana may be legal in the state of Oregon for adults over the age of 21, most providers do not allow it and therefore we cannot accept any student into the internship that tests positive for marijuana on their drug screen.

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If the College cancels a class, students are entitled to a full refund of tuition and applicable fees. In order to receive a refund, students must fill out an Add/Drop Form. Refunds are based on the following criteria:

Students must drop prior to first class in order to receive refund

Name_____
(Last) (First) (Middle)

Phone Number_____ (example 123-345-6789)

Email Address_____

Mailing Address Line 1 _____
Mailing Address Line 2 _____

City_____ **State**_____ **ZIP**_____

Date of Birth_____ **Gender** ☐ Male ☐ Female
MM/DD/YYYY

Marital Status ☐ Married ☐ Single **Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (check all that apply) ☐ African American/Black ☐ American Indian/Alaska Native
☐ Asian ☐ Pacific Islander ☐ White

Social Security Number _____

Providing your social security number is **not required for Community Education**.
If you plan to take credit classes and apply for Federal Financial Aid, it will be required.

Course Number	Course Name	Dates	Start/End Time	Cost

KCC is required to collect some of the data for institutional compliance. We appreciate your cooperation.
Non-Discrimination Policy: Klamath Community College is an equal opportunity educator and employer.

Total Cost $1940

Payment Options: (check one)

☐ Credit Card ☐ Enclosed Check ☐ Enclosed Cash ☐ Scholarship Name:_____

Card Number_____ Expiration Date_____

Name as it appears on card_____ ☐ Visa ☐ MasterCard ☐ Discover

I hereby certify that I have provided complete and accurate information on this form, and I understand that if it is found to be otherwise, it is sufficient cause for rejection or dismissal. Signature also confirms credit card payment.

_____

Student Printed Name Student Signature Date

HEPATITIS B VACCINATION

HEALTH PROFESSION STUDENTS

NAME_____
DATE_____COURSE_____ SECTION_____

HEPATITIS B VIRUS (HBV) causes a viral infection, which involves the liver. The spectrum of disease ranges from asymptomatic infection to fulminant disease, which may lead to death. Six to ten percent of infected young adults become carriers of the infection. Over 25 percent of these carriers develop chronic active Hepatitis, which often progresses to cirrhosis. There has been an association demonstrated between the Hepatitis B carrier state and the occurrence of liver cancer. The disease is spread by introducing infected blood or body fluids into the body by percutaneous or permucosal routes, i.e. sharps injury, getting infected blood or body fluids into non-intact skin or on mucous membranes, and by sexual contact and intravenous drug use. There is evidence that there is increased risk of HBV infection for health care workers who have frequent contact with blood and body fluids. In addition, more virulent form of Hepatitis is associated with superinfection or coinfection by Delta virus. Delta virus can only infect and cause illness in persons with Hepatitis B infection. Therefore, persons immune to HBV infection are also immune to Delta virus infection.

HEPATITIS B VACCINE immunizes against infection caused by all known subtypes of HBV. It is a vaccine prepared from cultures of a recombinant strain of yeast Saccharomyces cervisiae. The vaccine contains thimerosol (a mercury derivative) and as preservative.

INDICATIONS FOR USE: Hepatitis B vaccine is indicated for persons at increased risk for developing HBV infection and who are demonstrated to be susceptible to HBV. Risk is based on frequency of contact with blood or body fluids. Healthcare workers without occupational exposure to blood or body fluids are at no greater risk of infection then the general population.

PRIMARY ADULT VACCINATION consists of a series of three intramuscular injections of one ml. each. The first dose is given at the selected date. The second and third doses follow the first by one and six months, respectively. Administration of doses at longer intervals may be equally protective but optimal protection is not achieved until after the third dose. Vaccination of carriers will not cause harmful or beneficial effects.

ANTIBODY TESTING prior to receiving Hepatitis B vaccine is recommended to determine the immune status of the individual. Post-vaccine antibody testing is also recommended to determine immunity induced by the vaccine.

REVACCINATION NONRESPONDERS: When persons who do not respond to the primary vaccine series a revaccinated, 15%-25% produce an adequate antibody response after one additional dose and30%-50% after three additional doses.

BOOSTER DOSES for adults with normal immune status, booster doses of vaccine are not recommended, nor is routine serologic testing to assess antibody status after the primary post-vaccine antibody screening.

SIDE EFFECTS consist mostly of pain at the injection site (3%-29%) and a slight fever (1% to 6%).

PRECAUTIONS: Persons with hypersensitivity or allergic reaction to yeast or any other vaccine components should not be given recombinant Hepatitis B vaccine. Neither pregnancy nor lactation should be considered a contraindication to vaccination.

___I request Hepatitis B vaccine.

I have read the above information about Hepatitis B and Hepatitis B vaccine. I had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of Hepatitis B. I can contact my health care provider for the vaccination series at a cost to me at the time of the vaccinations.

Student Signature_____ Date: _____

___I decline Hepatitis B vaccine.

I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus infection. I have been given the opportunity to be vaccinated for the Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B a serious disease. If in the future I continue to have occupational exposure to blood or potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine. I can contact my health care provider for the vaccination series at a cost to me at the time of the vaccinations.

Student Signature_____ Date: _____

__I received the Hepatitis B vaccination series in the past at _____ (facility)

on_____ (approximate date)

Student Signature_____ Date: _____

Date Site Manuf/Lot # / exp. date Given by

1.

_____

2.

_____

3.

_____

FERPA Consent to Release Student Information

Office of Registrar · Building 3 · 7390 South Sixth Street · Klamath Falls, OR 97603

KLAMATH Community College

_____ _____ _____

Last Name First Name Student ID Number

It is the policy of Klamath Community College, in accordance with the Family Education Rights and Privacy Act (FERPA), to withhold personally identifiable information contained in our students' education records unless the student has consented to disclosure. Private information, such as grades, class schedules, the student's account, and financial aid awards may not be released without express consent from the student. Signing this form provides such consent, according to the information designated for release and to whom it is to be released.

I, _____, authorize Klamath Community College to release the following educational records, upon request, to the persons listed below, for the purpose of keeping them informed regarding my education at Klamath Community College.

Please initial all that apply:

_____ All financial records in the Business Office

_____ All Financial Aid Information

_____ All academic records in the Registrar Office

_____ All medical/ disability documents in Student Support Services

_____ Other: _____

_____ Other: _____

Persons to whom information can be released:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

All listed persons will have access to the initialed information/ departments above. If a person shall have access to different information than listed, student must complete a separate form for said person.

Please provide the contact information for the previously stated persons to whom information can be released.

Name:_____ Mailing Address: _____ _____ Phone Number: (_____) _____ Email: _____	Name:_____ Mailing Address: _____ _____ Phone Number: (_____) _____ Email: _____
Name:_____ Mailing Address: _____ _____ Phone Number: (_____) _____ Email: _____	Name:_____ Mailing Address: _____ _____ Phone Number: (_____) _____ Email: _____

I acknowledge by my signature that I understand that, although I am not required to release my records, I am giving my consent to release the designated information to the above named person(s). I understand that this release will remain in effect unless I revoke such consent in writing and the revocation is received and processed by Klamath Community College.

_____ _____

Student Signature Date

Office Use Only:

Received By: _____ Date: _____

KLAMATH
Community College

HIPPA CONFIDENTIALITY STATEMENT

I understand that during my clinical rotations I may have access to confidential information about clients, patients, their families and clinical facilities. I understand that I must maintain confidentiality of all verbal, written or electronic information and in some instances, the information may be protected by law, such as state practice acts or other regulatory standards. In addition, the client's right to privacy by judiciously protecting information of a confidential nature is part of the health professionals expected behavior.

Through this understanding and relationship to professional trust, I agree to discuss confidential information only in the clinical setting as it pertains to patient care and not where visitors and/or other patients may overhear it.

During each clinical rotation in the education program, I agree to follow each agency's established procedure on maintaining confidentiality.

_____ _____

STUDENT SIGNATURE DATE

_____

PRINTED NAME

Klamath Community College

7390 South 6th St.

Klamath Falls, OR 97603

WAIVER OF LIABILITY AND INFORMED CONSENT

Name _____ Student ID # _____

As a participant in the Klamath Community College (KCC) Phlebotomy Program, I have read, understand, and agree to the following:

- I willingly consent to participate in all laboratory treatments and practice sessions as a human subject (i.e. patient) for educational purposes at Klamath Community College. These treatments may be rendered by faculty or by fellow students.
- As a participant in a phlebotomy training program, I may be exposed to a variety of hazards and risks of injury, foreseen or unforeseen. While proper industry safety procedures will be discussed in the program, Klamath Community College and its program partners cannot eliminate the potential for such injuries. Furthermore, **it is my responsibility to disclose any information or medical issues that will limit or bar me from the above participation to the Instructor in a timely manner.**
- I agree that I am personally responsible for all risks associated with participation in the KCC Phlebotomy Program. To the fullest extent allowed by law, I agree to waive, release, discharge, and hold harmless Klamath Community College, its Board of Education, and all of its officers, agents, employees, and representatives from any and all liability, claims, causes of action, or demands arising out of any injuries to me or my property which may result from my participation in the KCC Phlebotomy Program.
- I willingly consent to appear in photographs, transparencies, films, videotapes, and other forms of media, for educational and informational purposes at Klamath Community College.
- I willing consent to give the Health Science Program Director or Klamath Community College Designee permission to give my Student Identification Number and other personal information to the Klamath Community College clinical affiliations and licensure/registration authorities for appropriate reasons. I willingly consent to give the Community Education Department permission to release drug testing results, or Criminal Offender Record Information (CORI) to clinic sites that may require such information as terms of their contract with Klamath Community College for clinical affiliations.

Signed _____ Date _____

KLAMATH Community College
Workforce & Community Education

Releases and Receipt of Forms

Consent to Release Confidential Information

Full Legal name:	Today's Date:

Release of Confidential Information

By signing below, I give permission for KCC to share my personal information to (insert here), & other agencies (*indicated here*) _____ in order for me to participate in this grant-funded program.

The agencies listed above will not discriminate against anyone and will help all who qualify. We will not deny help to anyone based on age, race, color, national origin, gender, ethnicity, sexual orientation, religion, political beliefs, or disability. If you believe you were discriminated against for any of these reasons, you may file a complaint.

- To file a complaint: Write to Klamath Community College: 7390 South 6th Street Klamath Falls, OR 97603

Participant Signature	*Date*

Media Release

I, _____, **authorize** KCC, and any additional agencies (*indicated here*) _____ to use my image, likeness, or name in media releases, promotional displays, on websites or on other printed or graphic materials.

I, _____, **do NOT authorize** KCC, and any additional agencies to use my image, likeness, or name in media releases, promotional displays, on websites or on other printed or graphic materials.

Participant Signature	*Date*

Confirmation of Equal Opportunity and Social Security Release Information

I verify I have received a copy of the Equal Opportunity and Social Security Number Release information.

Participant Signature	*Date*