



## Medical Assistant

Application & Registration Form

541.880.2243 | [ce@klamathcc.edu](mailto:ce@klamathcc.edu)

### **Program Mission:**

Students will be eligible to take the NHA (National Healthcare Association) certification exam to become a certified medical assistant. Students will be able to earn a non-credit training certificate from Klamath Community College.

### **Course Description:**

This 20-week course has 6 hours of classroom instruction per week and a 90-hour internship with a local provider to practice providing patient care on real patients. Clinical Medical Assistant is a medical support professional that performs a variety of tasks to assist physicians in providing patient care. This course will provide the student the skills needed to sit for the NHA (National Healthcareer Association) certification exam.

Participation and attendance are mandatory to be placed in an internship and to take the national certification exam.

This course has a student cap of 15 students. Students will be entered into the program on a first come, first serve basis.

### **Prerequisites & Program requirements:**

- High school graduate or GED equivalent
- Must be 18 years or older before class starts.
- Up to date on all vaccinations (Provide copy)
- Hepatitis B vaccine series & Tuberculin (TB) skin test (Provide copy)
- COVID-19 vaccination is required by Oregon Health Authority to participate in clinical internship.

### **Requirements to be completed during training:**

- BLS American Heart Association card
- Bloodborne Pathogens training

- Completion of agreement & internship orientation with clinic prior to internship
- Completion of 90- hour internship
- Start online application for Medical Assistant 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 & Background check (No refunds due to inability to pass background check/drug screen)
- Attend resume workshop

\*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.

If you have any questions about your ability to meet these requirements, please contact the Workforce/Community Education Department Coordinator at 541-880-2243.

### **Course Topics:**

1. Foundational Knowledge and Basic Science
2. Anatomy and Physiology
3. Patient Care Coordination, and Education
4. Administrative Assisting
5. Communication and Customer Service
6. Medical Law and Ethics
7. Clinical Patient Care
  - Patient Intake and Vitals (14 items)
  - General Patient Care (28 items)
  - Infection Control and Safety (15 items)
  - Point of Care Testing and Laboratory Procedures
  - Phlebotomy
  - EKG and Cardiovascular

### **Schedule:**

Our Medical Assistant program is offered once a year during the Winter term. It is two days a week, Tuesday and Thursday, 6pm-9pm. Saturday scheduled labs are mandatory.

Dates: Winter 2025 pending

### **Course Supplies:**

All supplies including a textbook is provided to all students. Students will need to purchase pressure cuff and scrubs.

**Course Cost: \$2,245**

Payment is due the first week of class. This class is not eligible for financial aid. A payment plan is available in installments of three. Please inquire with the Cashier's Office in Building 9.

**Student Grant Options:**

- **Community Benefits Navigator**  
Contact: Lalo Barraza ,971-380-5120, [barraza@klamathc.edu](mailto:barraza@klamathc.edu). Provides support and assistance to KCC students regarding food and housing, mental/physical health, childcare, employment, and funding.
- **STEP Program at Klamath Community College**  
Must be receiving SNAP benefits (food stamps).  
Contact: Reynda Scobee, STEP Coordinator, 541-880-2343, [Scobee@klamathcc.edu](mailto:Scobee@klamathcc.edu)
- **STEP Program at Worksource**  
Must be receiving SNAP benefits (food stamps). 30-day eligibility period  
Contact: Tangie, Lead STEP Coordinator,  
[Tangie.M.MCREYNOLDS@employ.oregon.gov](mailto:Tangie.M.MCREYNOLDS@employ.oregon.gov) or visit Worksource to make an appointment.
- **Workforce Innovation Opportunity Act (WIOA) Federal Program at Worksource & Klamath Works**  
Must be receiving SNAP, TANF, SSI, Dislocated worker/displaced homemaker or low-income. 30-day eligibility period  
Contact: Cristy Rodriguez, WIOA Manager, 541-591-1881,  
[cristy@klamathworks.com](mailto:cristy@klamathworks.com)
- **Vocational Rehabilitation training funds**  
Voc. Rehab assists individuals with disabilities for job placement that matches their skills, interest, and abilities.  
Contact: Tammi 541-883-5614

**Job Placement:**

- A resume and cover letter class are included in this course. KCC also has a Career

Center located in Building 4. They are able to provide job search assistance, resume, cover letter, and interviewing techniques.

**Application/Registration Process:**

- Please scan all documents in PDF version to [ce@klamathcc.edu](mailto:ce@klamathcc.edu) or make an appointment to submit your documentation in person.
- You will receive a letter of admissions to your email with next steps.

**Contact:**

Workforce/Community Education Coordinator

[ce@klamathcc.edu](mailto:ce@klamathcc.edu)

541-880-2243 (text/call)



# Medical Assistant

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ce@klamathcc.edu | [www.klamathcc.edu](http://www.klamathcc.edu)

Name \_\_\_\_\_  
(Last) (First) (Middle)

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Mailing Address Line 1 \_\_\_\_\_

Mailing Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_  
MM/DD/YYYY

Gender  Male  Female

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.

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.**

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.

### Payment Options: (check one)

Credit Card  Enclosed Check  Enclosed Cash  Scholarship Name: \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name as it appears on card \_\_\_\_\_

CVC # \_\_\_\_\_

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 payment.

Student Printed Name

Student Signature

Date



**KLAMATH**  
Community College

HEPATITIS B VACCINATION  
HEALTH PROFESSION  
STUDENTS

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 virusinfection.

HEPATITIS B VACCINE immunizes against infection caused by all known subtypes of HBV. It is a vaccine prepared fromcultures 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 andwho 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 thegeneral population.

PRIMARY ADULT VACCINATION consists of a series of three intramuscular injections of one ml. each. The first dose isgiven 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 afterthe 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 theindividual. 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 routineserologic 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 received the Hepatitis B vaccination series in the past at

\_\_\_\_\_ (facility) on

\_\_\_\_\_ (approximate date)

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

Date	Site	Given by
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1.	_____	_____
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2.	_____	_____
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3.	_____	_____
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## FERPA Consent to Release Student Information

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

\_\_\_\_\_

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 medical/ disability documents in Student Support Services

\_\_\_\_\_ All academic records in the Registrar Office

\_\_\_\_\_ 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: \_\_\_\_\_



## 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 nowhere 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.

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STUDENT SIGNATURE

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DATE

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PRINTED NAME



## WAIVER OF LIABILITY AND INFORMED CONSENT

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 willingly 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.

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STUDENT SIGNATURE

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DATE

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PRINTED NAME



**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.

\_\_\_\_\_

STUDENT SIGNATURE

\_\_\_\_\_

DATE

\_\_\_\_\_

PRINTED NAME