# RESPIRATORY CARE PROGRAM CHECKLIST
## New Applicants

**Required to Apply to Program:**

| |
|---|
| **Application for Program Admissions** |
| **Official College Transcript** |
| **College Degrees/Certifications** (if applicable) |
| **High School Diploma** (copy or transcript) |
| **Prerequisites** (BIOL 2301, BIOL 2302, MATH 1314, and ENGL 1301) |
| **Application Letter** (**hand-written**, not typed)<br>"Why I am interested in Respiratory Care" |
| **One Letter of Recommendation** |
| **Castle Branch-** Background Check and Drug Test (Purchase required Package TF76)<br>https://portal.castlebranch.com/TF76/spif/TF76/TF76 |

**After Accepted into Program, the following are required:**

| |
|---|
| **Castle Branch -** Medical Document Manager (Purchase required Package TF76im)<br>https://portal.castlebranch.com/TF76/spif/TF76/TF76im |
| **Immunization Records**: |
| - 1st Year TB (PPD) Test |
| - TB Chest X – Ray (if positive skin test) |
| - MMR #1 , & #2 |
| - Tdap |
| - Varicella Vaccine : #1, & #2, Illness |
| - Hepatitis B: #1, #2, #3, Booster |
| - Hepatitis: B Ab |
| - Influenza Vaccine (during flu season, once accepted into program) |
| - Meningitis (Exempt if student is 22 years of age or older) |
| **CPR/ Certified by American Heart Association** |
| **Physical Exam** (consist 3 medical documents to be completed) |
| **Data Arc -** www.dataarcc.ws |

# APPLICATION FOR PROGRAM ADMISSIONS

***Select Program of Interest:***

☐ *Diagnostic Medical Sonography ☐ *Radiologic Technology ☐ Emergency Medical Science
☐ *Respiratory Care Science ☐ *Medical Laboratory Technology

This application is for admission into the program beginning: ☐ FALL _____ / ☐ SPRING _____

**NOTE: Applicants must complete remedial requirements & program prerequisites by the application deadline of the term for which admission is sought.*

Date of Application: _____ Student ID #: _____

Full Legal Name: _____
*Last* *First* *Middle*

Current mailing address: _____
*Street*

_____
*City* *State* *Zip*

Current telephone: (  ) _____ *(where you can be reached between 8 a.m. and 5 p.m. on weekdays)*

Email Address: _____

If you have previously attended any school under a name other than that given above, please specify below:

_____

List other Allied Health Schools/Programs you have or will apply to:

| Allied Health School | Date of Application |
|---|---|
| _____ | _____ |
| _____ | _____ |

**PERSONAL INFORMATION**

☐ Male ☐ Female Place of Birth: _____

Ethnic Origin: (*OPTIONAL-for affirmative action purposes only*)

☐ White ☐ Hispanic ☐ Native American ☐ Prefer Not To Answer
☐ Black ☐ Asian ☐ International

Emergency Contact:

_____ _____
*Name* *Relationship*

_____
*Street Address*

_____ (  ) _____
*City, State, Zip* *Telephone*

Have you ever been convicted of a misdemeanor or felony (including deferred adjudication for either) with the exception of minor traffic violations (e.g. speeding or parking violations)? *Note: DUI's, DWI's, PI's are not minor traffic violations. ☐ Yes ☐ No
If "Yes," provide a written explanation.

Were you ever required to leave high school, college, graduate or professional school or ever denied readmission because of deficiencies either in conduct or scholarship? ☐Yes ☐ No If "Yes," provide a written explanation.

In order to provide better services for people with disabilities, the following voluntary information is needed. This is for affirmative action purposes. The information you provide will not affect your admission to the School of Health Sciences and will kept confidential.
Please check all that applies to you: ☐ physical disability ☐ learning disability ☐ other disability
Will you need accommodations in order to succeed in the program for which you are applying? ☐ yes ☐ no

**EDUCATIONAL BACKGROUND**

List the high school you attended and REQUEST THAT AN OFFICIAL TRANSCRIPT be sent the address shown below. *

Last High School Attended: _____ _____

School City/State Graduation Date

Please list each college or university that you have attended or will attend prior to enrolling at TSC. *(REQUEST THAT AN OFFICIAL TRANSCRIPT FROM EACH INSTITUTION SHOWING ALL WORK ATTEMPTED BE SENT DIRECTLY TO THE ADDRESS SHOWN BELOW).* *

| NAME OF SCHOOL | CITY | STATE | DATES ATTENDED | DIPLOMA/DEGREE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

*NOTE: If you have attended more than three colleges, please list on a separate sheet.*

Entrance exam (TASP, THEA, etc.) must be successfully completed prior to consideration of this application. *(Contact Testing Center, Student Services Building 956-295-3660 to arrange testing.)*

Date taken: _____ Or Scheduled: _____

List all college or university COURSES which **you are currently enrolled** or **will have completed before the program begins**, that DO NOT PRESENTLY APPEAR on your transcript.

| COLLEGE OR UNIVERSITY | COURSE NO. | COURSE TITLE | CREDIT HRS | TERM/YR |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I understand that the Admission Committee will not regard this application as "complete" until all supporting papers have been received; therefore, it is to my interest to see that these are submitted as promptly as possible. It is also my understanding that official transcripts sent directly from each school I have attended must be received as soon as possible and at the end of each successive semester, quarter, etc., for as long as my application is being considered. (Transcripts showing additional work after acceptance must also be submitted.)

If selected for admission to this program I will at all times conduct myself in accordance with the rules and regulations of the College, Program and its clinical affiliates. I certify that the information in this application is complete and correct and understand that the submission of false information is grounds for rejection of my application, withdrawal of any offer of acceptance, cancellation of enrollment, or appropriate disciplinary action.

_____ _____

*Signature of Applicant* *Date*

*If there are circumstances which may have an influence on your admission which you would like for those reviewing your application to know about, please describe on a separate sheet and attach.*

**DEADLINES FOR RECEIPT OF APPLICATION AND ALL REQUIRED DOCUMENTS:**

| PROGRAM | PROGRAM BEGINS | APPLICATION DEADLINE |
|---|---|---|
| Emergency Medical Science | Fall Semester | June 15 |
| Medical Laboratory Technology | Fall Semester | Last working day of June |
| Radiologic Technology | Spring Semester | Last working day of August |
| Respiratory Care Science | Fall Semester | Last working day of May |
| Diagnostic Medical Sonography | Fall Semester | Last working day of May (Noon) |

* *Application, transcripts, and supporting documents can be hand delivered to:* **Texas Southmost College**
**ITEC Center**
**301 Mexico Blvd Ste H3A**
**Brownsville, Texas 78520**

*The Texas Southmost College does not discriminate based on sex, race, color, national origin, handicap or age*

**Students please check one in this section.** *(Required Essential Functions can be found in Program Brochure)*

☐ **RADIOLOGIC TECHNOLOGY** ☐ **DIAGNOSTIC MEDICAL SONOGRAPHY** ☐ **MEDICAL LABORATORY TECHNOLOGY**

☐ I have reviewed and understand the required program essential functions and I believe that I meet all these standards.

☐ I am not sure if I meet one or more of these functions and I need further evaluation. Check one or more the of the following:

☐ Vision ☐ Speech and Hearing ☐ Fine Motor Function ☐ Psychological Stability

# Student Health, Immunization and Communicable Diseases Policy

The students will follow the guidelines set forth by TSC, the clinical sites, the Centers for Disease control, Occupational Safety and Health Administration (OSHA), and any other regulatory agency affiliated with both TSC and the practicum affiliates.

**GUIDELINES:**

1. Students are financially responsible for their personal health care/hospitalization costs incurred while participating in the Respiratory Care Science Program.

2. Students must obtain a physical exam and submit it to the Respiratory Care Science Program before beginning clinicals. Students are required to maintain current immunizations. This includes yearly TB testing, yearly flu shots, Hepatitis B vaccine series, tetanus (every 10 yrs.), and other routine childhood immunizations. Students must be current on appropriate immunizations to be allowed in the clinical sites. For this reason, all required records must be submitted prior to the first clinical semester.

3. **If a student is unable to meet clinical objectives due to the presence of a communicable disease, a passing clinical grade cannot be obtained.**

4. In the event that a student becomes exposed to a communicable disease, the following procedures are recommended: (Hepatitis, Tuberculosis, Mumps, Measles, etc.)
   a. Report exposure to clinical instructor, authorities in health care agencies, and educational institution.
   b. Assess the clinical status of the source-client.
   c. Test the exposed individual soon after possible exposure.
   d. Retest in 6 weeks, 3, 6, and 12 month intervals with a private physician
   e. Seek counseling and adhere to the recommendations for the prevention of transmission of infections or communicable diseases.
   f. Confidentiality of medical records is protected and information is shared only on a strictest "need to know" basis.
   g. Confidential screening for various communicable diseases can be obtained through the Cameron County Health Department.

**TEXAS SOUTHMOST COLLEGE**
**GENERAL PHYSICAL EXAM**

*As a minimum requirement, this physical exam form must be completed yearly prior to participation in any participation in any practice or game/matches*

Full Name_____Birth Date_____ Age_____ Sex_____

ID#_____

Height_____ Weight_____ %Body Fat (optional)_____ Pulse_____ B/P____/___(___/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal_____ Unequal_____

| | Normal | Abnormal Findings | Initials* |
|---|---|---|---|
| MEDICAL | | | |
| Appearance | | | |
| Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart-Auscultation of the heart in the supine position | | | |
| Heart-Lower eternity pulses | | | |
| Pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitalia (males only) | | | |
| Skin | | | |
| MUSCULOSKELETAL | | | |
| Neck | | | |
| Back | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |

* station-based examination only

CLEARANCE

Cleared

Cleared after completing evaluation/rehabilitation for: _____

_____

_____

Not cleared for: _____ Reason:_____

Recommendation:_____

_____

*The following must be filled in and signed by a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an advanced Practice Nurse by the Board of Nurse Examiners.*

Name (print/type) _____ Date Examination_____

Address: _____

Phone Number: _____

Signature: _____

# Report of Health Evaluation

**TO THE EXAMINING PHYSICIAN:** Please review the students' history and complete the physician forms. Please comment on all positive answers. This information will be used only as a background for providing health care, if necessary.

| Student Name: | | |
|---|---|---|
| Blood Pressure | Height in inches | Weight in pounds |

| ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? | | | |
|---|---|---|---|
| SYSTEM | YES | NO | COMMENTS |
| Head/Ears/Nose/Throat | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Gastrointestinal | | | |
| Hernia | | | |
| Genitourinary | | | |
| Musculoskeletal | | | |
| Metabolic/Endocrine | | | |
| Neuropsychiatric | | | |
| Skin | | | |
| Gynecological/OB | | | |
| Are there any speech/vision/hearing impairments? | | | |
| Eyes | | | Vision: Lt. Rt. Corrected: |
| Hearing | | | Hearing: Lt. Rt. Corrected: |

In my opinion, is this individual in suitable physical and emotional condition for this Allied Health Program? ☐ Unlimited ☐ Limited Please explain: _____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Print Physician's Name Business Number

_____

Address City State Zip

## Allied Health Programs

### Report of Medical History

| Last Name: | First: | Middle: | Maiden: |
|---|---|---|---|
| Address | | | |
| Phone | | Date of Birth | |

## Emergency Notification

Person to notify in case of emergency

| Last Name: | First: | Middle: |
|---|---|---|
| Address | | |
| Home Phone | Work Phone | Relationship |

## Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

| HAVE YOU HAD? | YES | NO | HAVE YOU HAD? | YES | NO |
|---|---|---|---|---|---|
| Measles | | | Seizures | | |
| Mumps | | | Dizziness, Fainting | | |
| Rubella | | | Weakness, Paralysis | | |
| Chicken Pox | | | Joint Problems | | |
| Diabetes | | | Back Problems | | |
| Tuberculosis | | | Gastrointestinal Problems | | |
| Hepatitis A/B/C | | | Heart Problems | | |
| Visual Impairment | | | Malignancy | | |
| Hearing Impairment | | | Respiratory Problems | | |
| Surgery | | | Hernia | | |
| Recurrent Headache | | | Allergies | | |
| Any UNEXLAINED weight loss (greater than 10 pounds)? | | | | | |
| Have you had any illness/injury or been hospitalized other than already noted | | | | | |
| Is your ability to practice safe professional medical care adversely affected by a physical or mental disability/illness which may endanger the health and safety of persons under your care? | | | | | |

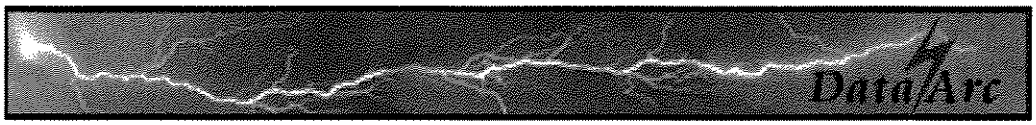
EXPLAINE "YES" ANSWERS: _____

_____

_____

_____ _____

Student Signature Date




# Respiratory Care
# Student Credit Card Order Form

To process your order the following information is needed.

| Contact Information | |
|---|---|
| Name | |
| Email Address | |
| Phone Number | |
| Shipping Address | |
| **Payment Information** | |
| Credit Card Type | O Discover O Master Card O Visa |
| Name on Card | |
| Card Number | |
| Expiration Date | |
| Your Mailing Address for Credit Card Statements | |
| **Program Information** | |
| Name of Program | |
| CoARC # | |
| | |

| | | |
|---|---|---|
| Number of Student Licenses (1 per student @ $60.00 each) | # ___ of Licenses x $60.00 | |
| | UPS Shipping and Handling (1-25 CD's $10.00; 26-50 CD's $15.00) | |
| | Total Purchase Price | |

Orders can be sent to DataArc in the following formats:

Mailed to: DataArc, LLC
2951 Marina Bay Dr. 130-355
League City, TX 77573

Fax to: (281)538-8972

Email to: orders@dataarc.ws

DataArc, LLC Tax ID: 76-0653886
Phone: 1-(866)328-2552
Fax: (281)538-8972

Thank you for your interest and we look forward to continuing your services.