RESPIRATORY CARE PROGRAM CHECKLIST

New Applicants

Student's Name	TSC ID #	Phone #	Completed

Required:	**Date**
Application: Due last working day of May	
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) "Why I am interested in Respiratory Care"	
One Letter of Recommendation	
Castle Branch Purchase required : (Background Check, Drug Test, and Medical Documents) https://portal.castlebranch.com/tf76 (purchase package TF76 and TF76im)	
CPR/ Certified by American Heart Association (copy of most recent one) Will be discussed during Orientation	
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)	
Physical Exam (complete all 3 medical documents attached)	
Data Arc: www.dataarcc.ws (Purchase required after acceptance into program. Will be provided during orientation if accepted into the RSPT Program.)	

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 should be mailed to:*

(Indicate the Name of the Program)
Texas Southmost College
80 Fort Brown
Brownsville, Texas 78520-4993

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 practicum 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 Therapy Program.

2. Students must obtain a physical exam and submit it to the TSC Health Center before beginning the clinical practicum. The student's health records will be maintained in the Student Health Center and the Student Health Center will notify the Respiratory Therapy department when the student has been cleared for clinical practicum. 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 practicum sites. For this reason, all required records must be submitted prior to the first practicum rotation.

3. **If a student is unable to meet practicum objectives due to the presence of a communicable disease, a passing practicum 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:_____

Revised 12/2013

Report of Health Evaluation

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

Student Name			SSN
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: Yes No
Hearing			Hearing: Lt. Rt. Corrected: Yes No

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

Physician's Signature _____ Date _____

Print Last Name _____ First _____ Phone (voice) _____

Address _____ City _____ State _____ Zip _____ Phone (fax) _____

This form can be Hand-Carried in attached sealed envelope by student, Faxed or returned by mail to the appropriate Allied Health Program. Address on front of this form;

Allied Health Programs

Please Check the appropriate program:

0 ADN 0 PTA
0 DENTAL 0 RAD TECH
0 EMS 0 VOCN
0 MHIT

Allied Health Campus, Fax: ()

Report of Medical History

Last Name	First	Middle	Maiden
Address – Number & Street	City	State	ZIP
Phone	Date of Birth	SS#	Sex

Emergency Notification

Person to notify in case of emergency

Last Name	First	Middle	
Address - Number & Street	City	State	ZIP
Home Phone	Work Phone	Pager	Relationship

Personal History

ANSWER ALL QUESTIONS. EXPLAIN "YES" ANSWERS BELOW:

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Measles (rubeola)			Seizures		
Mumps			Dizziness, Fainting		
Rubella (German Measles)			Weakness, Paralysis		
Chicken Pox (varicella)			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 UNEXPLAINED 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?					

EXPLAIN "YES" ANSWERS: _____

(Student) I verify that all of the above is true and complete to the best of my knowledge.

_____ Student Signature

_____ Date

NOTE: BACKSIDE OF FORM TO BE COMPLETED BY HEALTH CARE PROVIDER

CastleBranch

Texas Southmost College

How to Place Order

Welcome to myCB

To place your initial order, you will be prompted to create your secure myCB account. From within myCB, you will be able to:

- View order results
- Upload documents
- Manage requirements
- Place additional orders
- Complete tasks

Please have ready personal identifying information needed for security purposes.

The email address you provide will become your username.

Contact Us: **888.914.7279** or **servicedesk.cu@castlebranch.com**

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.