Registered Medical Assistant Program
Fall 2018

September 11, 2018 – July 17, 2019

Program Information:

Thank you for your interest in the Registered Medical Assistant Program at Tunxis Community College. This 725 hour, 10-month program has been approved by the American Medical Technologists (AMT) and is limited to 15 students who are accepted on a first come, first served basis. Upon successful completion, students are eligible to sit for the AMT national examination. Classroom instruction and lab groups are held at the college. Clinical internships are held at physicians' offices and clinics within our college service area.

Program Requirements:

You must be at least 18 years old and complete the following:

- Fill out the enclosed RMA application, Physical Verification form, and Questionnaire
- Submit a copy of your high school diploma or GED
- Mail or bring the application and forms to Continuing Education, Tunxis Community College, 271 Scott Swamp Road, Farmington, CT 06032.

It is the applicant's responsibility to make sure all materials have been received. Only completed applications will be reviewed.

Your application will be forwarded to the Allied Health Coordinator for consideration. If accepted, you will be notified in writing and given further instructions to complete your enrollment.

Tuition Payment:

Once you are accepted, tuition must be paid to the College within five business days of notification. **Refunds may be obtained only if your written withdrawal is received by the Continuing Education Office five (5) business days prior to the Mandatory Orientation Session on September 11, 2018**. Students will not be allowed into the classroom until they have started payments.

Your tuition includes the cost of malpractice insurance, textbooks, uniforms, and AMT Examination fee (see Costs sheet on page 3).

Required Uniform (handed out in class):

- Ceil blue scrub top and pants
- Black sneakers, shoes or Crocs (cannot be open-toed)
- A watch with a second hand

Health Requirements:

Each student accepted into the program must have a health examination along with required immunizations. See "RMA Program Checklist" sheet for details. No student can be permitted to participate without these requirements. **The original health form is due in its entirety by December 7th (no faxes).**

Online Requirements:

This program contains an on-site and an online portion. An Internet access point, like the Tunxis Library or your home service provider, is required for successful completion. Online classes are listed in the schedule portion of this packet.

Students who successfully complete the program are eligible to receive college credit through the Connecticut Credit Assessment Program administered by Charter Oak State College. Credits may be used at Charter Oak State College or transferred to another school by setting up a credit registry with Charter Oak (any transfer credit is at the discretion of the institution). For information visit

http://www.charteroak.edu/current/programs/creditregistry.cfm

Please be advised that if you have been convicted of a felony or misdemeanor, you may not be eligible for clinical experiences, internships, externships or certifications associated with certain Allied Health courses or programs. Those with previous convictions may also find it difficult to secure employment within a health care agency or institution.

REGISTERED MEDICAL ASSISTANT PROGRAM COSTS
FALL 2018

$ 7,950 – total cost

Includes tuition, administrative fee, malpractice insurance, textbooks, uniforms and national examination.

Books and Uniforms will be handed out the first day of class. Uniform consists of two pair of ceil blue scrub pants and two tops; black shoes; watch with a second hand; stethoscope.
Program cost must be paid or a payment plan started.

Payment Plan Option: monthly payment plan available ($25 installment plan fee)

To use the payment plan option, contact the Continuing Education office at least one day in advance, at 860 773-1448 or tx-continuing-ed@tunxis.edu.
You can then set up your payment plan in person at the Business Office (Founders Hall).

Loan Option

Connecticut Higher Education Supplemental Loan Authority – *https://www.chesla.org*
The CHESLA Loan is a low-cost fixed interest rate student loan available to Connecticut residents attending college in-state or out-of-state and to U.S. students attending college in Connecticut.

Costs associated with the program but not payable to TCC:

$75-100 (estimated) background check fee for UConn externship

$25 (estimated) parking fees for UConn externship

This program is not eligible for federal financial aid

Funding options may be available through CT Works (WIOA) and the
CT Department of Labor.
To see if you qualify, call New Britain CT Works at 860.899.3500.
For a complete listing of services and locations, please visit: ctdol.state.ct.us

TUNXIS COMMUNITY COLLEGE RMA PROGRAM
CHECKLIST

Application deadline is Wednesday, September 5; program begins Tuesday, September 11.

Checklist:

- ✓ **Step 1:** All applicants must complete and submit an **application packet,** along with a copy of your high school diploma or GED. Completed applications should be submitted to the Continuing Education office.

- ✓ **Step 2:** Attend the required **interview**. Interviews are scheduled individually. Please call Shaina Hamel, LPN 860.773.1454 or Cheryl Conaty, RN 860.773.1453 to set up a date and time.

- ✓ **Step 3:** Once you receive your acceptance packet, you must pay the full **tuition** or the first payment plan installment within five business days of acceptance.

- ✓ **Step 4:** Bring the **health form** (included in this application packet) to your physician and have it completed and signed. Completed forms cannot be submitted by fax; only original completed forms will be accepted. Health forms are due on **Friday, December 7.**

Continuing Education Office Hours
Monday, Tuesday, & Wednesday, 9:00AM-6:00PM
Thursday, 9:00AM-6:30PM
Friday, 9:00AM-5PM
860.773.1450

Cheryl Conaty, RN, Allied Health Coordinator Office Hours
Monday-Friday
7:00AM-2:30PM
Room 6-216
860.773.1453

Fall 2018 Medical Assistant Schedule

Mandatory Orientation: Tuesday, September 11, 2018
9AM-12PM Location: Room 306

Section 1

No classes November 19 - 23

Lab 1: Clinical Office Procedures
September 18 – December 4 (T&Th) 8:30-11:30AM
December 6 (Th) 8:30-10:30AM
Location: 306

Law, Liability & Ethics
September 19 – 27 (W&Th) 12-3:30PM
October 3 – 25 (W&Th) 12-3:15PM
Location: 205

Therapeutic Communication
October 30 – December 4 (T&Th) 12-2PM
December 6 (Th) 11AM-1PM
Location: 205

Ed2Go.com/Tunxis online courses:

Computer Skills for the Workplace
Sept. 12 – Nov. 2
Medical Terminology
Oct. 17 – Dec. 7
Medical Terminology II
Nov. 14 – Jan. 4
Human Anatomy & Physiology I
Dec. 12 – Feb. 1

Section 2

Seeking Employment
December 11 – 18 (T&Th) 9AM-Noon
Location: 306

No classes December 25, 2018 – January 2, 2019

Lab 2: Phlebotomy & Pharmacology
January 3 – March 5 (T&Th) 8:30AM-1PM
Location: 306

Medical Coding & Electronic Health Records
January 15 – February 7 (T&Th) 1:30-4:30PM
Location: 205

Ed2Go.com/Tunxis online course:

Human Anatomy & Physiology II
January 16 – March 8

Section 3

Medical Office Procedures
February 12 – April 4 (T&Th) 1:30-4:30PM
April 9 (T) 1:30-3:30PM
Location: 205

EKG Skills
March 6 – April 3 (W) 5-9PM
Location: 202

Lab 3: Surgical Procedures & Sterilization
March 7 – April 16 (T&Th) 8:30AM-1PM
Location: 306

Section 4

Exam Review
April 18 (Th) 9AM-12PM
Location: 306

CPR/BLS for Health Care Professionals
April 19 (F) 9AM-12PM
Location: Founders Hall

Internship
Dates/Times to be scheduled individually.
All courses must be completed with a passing grade of at least 70 in order for students to be eligible for internship.

Lab Review
April 23, 24, 25 (T, W, Th) 9AM-3PM
Location: 306

Graduation: Wednesday July 17, 2019 1:00PM

BANNER ID _____ REC'D ON _____ CC _____ CRN _____

TUNXIS COMMUNITY COLLEGE
REGISTERED MEDICAL ASSISTANT PROGRAM
FALL 2018

Name_____ Date of Birth_____
last first middle

Home Address_____
street city state zip

E-mail Address_____

Phone_____ Work / Cell Phone_____ SSN#_____

Gender: ☐ Male ☐ Female Primary Language_____

Ethnic/Racial (optional): ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Emergency Contact Name_____ Phone #_____

Are you a U.S. Citizen? ☐ Yes ☐ No If no, are you an alien who has the legal right to work? ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor? ☐ No ☐ Yes—briefly explain below.
*An arrest record could affect your ability to obtain employment as a RMA.

EDUCATIONAL INFORMATION

High School or GED Certification_____
(school attended and year graduated or certified)

College or University _____
(school attended, degree, and year graduated)

Are you competent in reading comprehension and able to do math computation? ☐ Yes ☐ No
If no, please explain.

List employment history below.

Tuition Payment Source ☐ Self ☐ Agency (agency name, caseworker and phone number **required** below):

_____

Tuition paid by: Check Number _____ Money Order _____ ☐ Agency

MasterCard/Visa/Discover: _____ Exp. Date _____

I understand the refund policy means I must contact the CE office three business days prior to the start of the mandatory class, and that no refunds will be issued after that time under any circumstances.

The information provided on this registration form is complete and accurate.

Signed_____ Date_____

TUNXIS COMMUNITY COLLEGE
REGISTERED MEDICAL ASSISTANT PROGRAM

Name:_____

Do you have transportation? ☐ **Yes** ☐ **No**

Tell us about yourself.

Five qualities you possess that would make you a good candidate for the program:

Do you know what being a RMA entails? Briefly describe.

Why are you interested in this program?

How can Tunxis be assured that you will be committed to the program?

Do you have any physical limitations? If yes, please describe.

Have you ever been arrested? If yes, please explain.

How did you hear about this course?

Student Signature: _____Date: _____

Tunxis Community College
271 Scott Swamp Road
Farmington, Connecticut 06032

MEDICAL ASSISTANT PROGRAM

PHYSICAL VERIFICATION FORM

***Name of Student*_____**

***Address*_____**

***City*_____ *State*_____ *Zip Code*_____**

Check the appropriate answer.
Please answer as honestly as possible. <u>If yes is checked, please provide an explanation.</u>

Allergies?	☐ **Yes**	☐ **No**
Pregnant?	☐ **Yes**	☐ **No**
On Medication?	☐ **Yes**	☐ **No**
Mental Health Concerns?	☐ **Yes**	☐ **No**
Hearing Problems?	☐ **Yes**	☐ **No**
Back Problems?	☐ **Yes**	☐ **No**
Knee Problems?	☐ **Yes**	☐ **No**
Recent Surgeries?	☐ **Yes**	☐ **No**
Lifting Restrictions? ***(i.e. arthritis, injury, surgeries, etc.)***	☐ **Yes**	☐ **No**
Latex Allergy?	☐ **Yes**	☐ **No**

Please list any medications here:

_____

_____

_____

If you are pregnant, have any back problems/lifting restrictions, or a medical condition that is being monitored by a physician, a form will be provided by the College that must be completed by your physician along with your signature.

Please list any other conditions that you feel may present a risk for you or that your instructor should be aware of to protect your well-being and safety.

_____

_____

_____

Student Signature _____ Date:_____

BOARD OF REGENTS FOR HIGHER EDUCATION
Tunxis Community College

Activity Waiver Form

Participant's name: _____
Please Print

In consideration of being permitted to participate in the **Registered Medical Assistant Program**, I, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge, and covenant not to sue **Tunxis Community College and/or the Board of Regents for Higher Education, their trustees, officers, employees, and agents** and to indemnify them from liability for any and all claims resulting from personal injury, accidents or illnesses (including death), and property damage or destruction arising from, but not limited to, participation in the Activity.

_____
Signature of Participant Date

I understand that participation in the Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, sprains, needle sticks 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks and concussions, to 3) catastrophic injuries including paralysis and death, to 4) exposure to blood or body fluids.

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in the Activity. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

I also agree to indemnify and hold the College harmless from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, brought as a result of my involvement in the Activity and to reimburse them for any such expenses incurred.

I further expressly agree that the foregoing waiver and assumption of risk agreement is intended to be as broad and inclusive as is permitted by the law of the State of Connecticut and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Finally, I have read this waiver of liability, assumption of risk and indemnity agreement, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend it by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_____
Signature of Participant Date

Tunxis Community College
Non-Credit Allied Health Programs

Health Form Requirements Checklist

Please use this checklist to guide you through the process of submitting an accurate and fully-completed health form.

Fill out Page 1

Check which program you're in	**Check_____**
Last 4 digits of your Social Security Number	**Check _____**
Under personal history, if you check yes, please explain.	**Check_____**
Banner ID# on EVERY PAGE SUBMITTED	**Check _____**

Page 2 – must be filled out by your physician, PA or APRN

All students are required to provide either proof of immunization or laboratory results of immunity. TITERS chosen for proof of immunization MUST BE POSITIVE and the LABORATORY REPORT MUST ACCOMPANY THE HEALTH FORM.

1. **MMR – dates of immunization or blood titer that shows immunity written on health form – attach document to show proof. Check _____**
2. **Polio – date(s) of immunization or blood titers that show immunity written on health form - attach document to show proof. Check _____**
3. **Chickenpox - dates of immunization, date of illness, or lab report that shows immunity written on the health form – attach document to show proof. Check _____**
4. **Tetanus booster – must be within the last 10 years, written on health form, attach proof of injection to the health form. Check _____**
5. **Flu vaccine (spring & fall applicants only) - date of vaccine written on the health form. Check _____ (If declination, your health care provider must provide a note.) Attach document to show proof.**
6. **Hepatitis B series - date(s) of injection or lab report written on the health form. Check _____ If a student hasn't received all 3 injections or refuses the series, a Hepatitis B waiver form (included in application packet) must be signed. Attach document to show proof. Check _____**
7. **Tuberculin Test/PPD (Mantoux or QF-G) – date given, date read, and results written on the health form. Attach document to show proof. Check _____ A positive PPD or previous inoculation of BCG, must be accompanied by a chest x-ray with the appropriate follow-up. Check _____**

(OVER)

Health Form Requirements (continued)

Physical Examination- All areas must be filled out in this section. Heart rate and Blood Pressure must be done. Nothing can be deferred. **Check _____**

A Urinalysis and Hematocrit or Hemoglobin must be documented with a number on the health form. Attach document to show proof.

Check _____

Date, Examining MD, PA, or APRN's signature must be completed along with the address completely filled out and a phone number. **Check _____**

Submit to the classroom instructor or Allied Health Coordinator Cheryl Conaty, R.N. (Room 6-216).

****Please make sure the entire health form is completed before submitting it.****

****Make a copy of your health form for your own personal records before handing it in.****

****Please do not staple forms together; paper clip them or use an envelope.****

Thank You.
Cheryl Conaty, RN
Allied Health Coordinator
Tunxis Community College
Continuing Education and Workforce Development
860-773-1453

STUDENT HEALTH FORM

Banner ID: _____

☐ **MAA**
☐ **MA**
☐ **CNA**
☐ **PHLEBOTOMY**

Tunxis Community College
Education That Works For a Lifetime

Board of Regents for Higher Education

TUNXIS COMMUNITY COLLEGE, Attention: Cheryl Conaty, RN
271 Scott Swamp Road • Farmington, Connecticut 06032-3187

APPLICANT: Please print. Complete this side.
EXAMINING PHYSICIAN: Please print. Complete reverse side ASAP and return to address above.

APPLICANT

Name (last, first, middle) — Social Security # ☐☐☐☐

Permanent Home Address (number & street, city or town, state, zip code) — Telephone # (include area code)

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Birth (month, day, year)

IN CASE OF EMERGENCY

Name (last, first, middle) — Relationship

Address (number & street, city or town, state, zip code) — Telephone # (include area code)

FAMILY HISTORY

Has any family member ever had the following:

☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ ALLERGY OR ASTHMA ☐ EPILEPSY OR CONVULSIONS ☐ STROKE
☐ HEART DISEASE ☐ NERVOUS OR MENTAL ILLNESS ☐ MIGRAINE HEADACHES ☐ HIGH BLOOD PRESSURE

PERSONAL HISTORY

Have you ever had:	YES	NO		Have you ever had:	YES	NO	Have you ever had:	YES	NO
1. MEASLES			ITEMS 6-15 •	6. RHEUMATIC FEVER			11. CONVULSIONS		
2. MUMPS			*All "Yes" answers must be explained below.*	7. HEART DISEASE			12. HIGH BLOOD PRESSURE		
3. CHICKEN POX				8. HEART MURMUR			13. ALLERGIES		
4. GERMAN MEASLES				9. DIABETES			14. FAINTING SPELLS		
5. WHOOPING COUGH				10. TUBERCULOSIS			15. HEPATITIS		

QUESTION	YES	NO	If "YES," please explain:
1. Have you ever had any operations and/or significant injuries?			
2. Do you have any physical impairment? (eg., paralysis, loss of hearing, vision)			
3. Have you had any emotional problems requiring treatment?			
4. Do you take any medications regularly?			
5. Have you reacted unfavorably to any medication? (eg., penicillin, aspirin)			
6. Has your physical activity ever been limited?			

SIGNATURE(S)

Date — Student's Signature (if under the age of 18, parent or guardian must also sign)

PERMISSION TO TREAT MINOR INJURY OR ILLNESS

I hereby grant permission to the medical staff of the college to render or secure proper treatment for my daughter, son or ward (named above). It is my understanding that I will be notified in case of any illness or injury of major proportion. In addition, I grant permission to the college physician to hospitalize this student in case of a surgical emergency requiring the administration of anaesthesia provided that the physician is unable to communicate with me and that, in his/her judgement, delay might endanger the life of the student.

Date — Parent's or Guardian's Signature

THIS SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY

IMMUNIZATION HISTORY

ALL students are required to provide proof of either immunization or laboratory results of immunity. **TITERS** chosen for proof of immunization **MUST BE POSITIVE** and the **LABORATORY REPORT MUST ACCOMPANY THIS FORM**.

MEASLES 1st dose: _____ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday & after Jan. 1, 1969

MEASLES 2nd dose: _____
date/given after Jan. 1, 1980

MUMPS: _____ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday

RUBELLA: _____ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday

POLIO: _____ or Titer Immune? ❑ YES ❑ NO
date(s) of immunization

VARICELLA (Chicken Pox): _____ or Titer Immune? ❑ YES ❑ NO
date(s) of immunization

Td (TETANUS booster): _____
date/must have been given within the last 10 years

IMPORTANT!
Attach lab reports or immunization records for everything listed.

FLU VACCINE (spring and fall applicants only) _____
date given

HEPATITIS B SERIES: _____ _____ _____ Risk Form_____
date/1st dose date/2nd dose date/3rd dose intial

***TUBERCULIN TEST/PPD** (Mantoux or QFT-G): _____ _____ _____
date given date read results

PHYSICAL EXAMINATION

HEIGHT	WEIGHT	COMMENTS and RECOMMENDATIONS			
EYES	VISION (R)	(L)	CORRECTION (R)	(L)	
EARS	DRUMS	HEARING (R)	(L)		
NASOPHARYNX	SEPTUM	TONSILS			
TEETH	OCCLUSION	CARIES	GINGIVITIS		
NECK	CERVICAL NODES	THYROID			
CHEST	BREASTS	LUNGS			
	HEART (Rate)	(Rhythm)	(Murmurs)	(Blood Pressure)	
ABDOMEN	LIVER	SPLEEN		HERNIA	
SKELETAL	SPINE	JOINTS	FEET		
CNS	REFLEXES				
LABORATORY	URINALYSIS ***(Lab Reports Required)***	HEMATOCRIT OR HEMOGLOBIN ***(Lab Reports Required)***			

I believe this student is able to participate in a full academic and clinical program (unless otherwise noted above).

DATE	EXAMINING PHYSICIAN'S SIGNATURE	ADDRESS	TELEPHONE
	M.D.		

For Office Use Only

BANNER ID @_____

Tunxis Community College

HEPATITIS B RISK FORM

I understand that due to my potential exposure to blood, body fluids and other potential infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that because I have either waived or not completed the Hepatitis B vaccination series, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I understand that if I experience an exposure to blood, body fluids or other infectious materials, I must notify my preceptor and/or instructor immediately. I will be directed to the Emergency Department where I will be offered the Hepatitis B virus immune globulin (HBIG), an injection(s). This injection provides temporary passive immunity from Hepatitis B. I will need to continue or start the Hepatitis B vaccination series.

By my signature below I acknowledge understanding that I (the student) am solely responsible for payment of all services, injections, vaccinations and other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have not completed the Hepatitis B vaccination series. I further understand that the College, its employees and clinical sites, will not be responsible for any services, injections, vaccinations or other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have waived or not completed the Hepatitis B vaccination series.

I have received information about Hepatitis B and the risks of exposure to blood, body fluids and other potential infectious materials and my responsibility in reporting any incident of possible exposure.

_____

Student's name – please print

_____ _____

Student's signature Date