

MEDICAL ASSISTING CERTIFICATE PROGRAM APPLICATION PACKET

Application Instructions

Thank you for your interest in the Medical Assisting Certificate Program at the College of Continuing and Professional Education at Kennesaw State University. Please read the following instructions carefully.

Type or print this application in blue or black ink.

To be considered for this program, please complete and return **ALL** sections of the Application Packet:

1. **Skills Assessment & Program Application** (Taken online through our website. Results automatically sent to KSU.)
2. **Student Information**
3. **Release, Waiver of Liability & Covenant Not To Sue**
4. **Human Subjects Document**
5. **Background Check Information**
6. **Health History & Immunizations** (Must be completed by Healthcare Provider. If you have Titters, you must attach a values report.)

Students must also provide a clear copy of the following with their Application Packet:

7. Current, personal Health Insurance card (front and back)
8. Driver's License
9. Social Security Card

HOW TO RETURN COMPLETED APPLICATION PACKETS

In Person:

KSU Center (South Entrance)
Attn: Healthcare Applications
3333 Busbee Drive
Kennesaw, Georgia 30144

By Mail:

KSU Center, Registration Department
Attn: Healthcare Applications
3333 Busbee Drive, MD 3301
Kennesaw, Georgia 30144-5591

Estimated Expenses

Students will be responsible for the following items. More information and directions on how and when to purchase will be provided after you are enrolled in the program. These are minimum, estimated costs to help you plan accordingly.

- Criminal Background Check, Drug Screen \$80**
- TB Skin Test, Seasonal Flu Shot \$50**
- Uniforms \$150
- Stethoscope \$60
- Watch with secondhand \$20
- White Shoes \$50
- NHA Certification Exam \$155

** Students in the Medical Assisting Certificate Program may be required to complete an additional criminal background check, drug screen, TB Skin Test, or seasonal flu shot prior to participation in the onsite clinical externship portion of the program. Based on the results of the criminal background check and drug screen, hospitals or clinical facilities where you will participate in onsite training may deny you access to their facility – resulting in your inability to successfully complete the Medical Assisting Certificate Program. If you are unable to complete the clinical portion of your training, you will be unable to progress in the program.

TB Skin Test Locations

East Cobb Healthcare Center
4938 Lower Roswell Road
(678) 784-2180

Hours: M-W 8-11am & 1-4pm, Friday by appointment only

Cost: \$31

Flu Shot: \$15-25

Marietta Health Center
1650 County Services Pkwy.
(770) 514-2300

Hours: M, W, F 8-11am & 1-4pm

Cost: \$31

Flu Shot: \$25

Textbooks are required for the program and available at the KSU Center Bookstore. For more information, visit bookstore.kennesaw.edu or call (470) 578-2342. The KSU Center Bookstore is open Monday – Thursday from 4-8pm and Saturday from 8:30-11:30am.

Student Information

Personal Information				
NAME	_____			
	<i>Last</i>	<i>First</i>	<i>Middle</i>	<i>Maiden</i>
ADDRESS	_____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
PHONE	()	()	()	
	<i>Daytime</i>	<i>Cell</i>	<i>Evening</i>	
EMAIL	_____			
	<i>All correspondence regarding the program will be sent to this email address</i>			
PERSONAL:	_____			
	<i>Date of Birth</i>			

Short Answer

Why do you want to become a Medical Assistant?

I affirm, agree, and/or understand that all statements on this form are true and accurate; any misrepresentation or omission of material facts may result in removal from the program.

_____	_____
<i>Signature of Applicant</i>	<i>Date</i>

FOR OFFICE USE ONLY:

Date Received: _____



College of Continuing
and Professional Education

RELEASE, WAIVER OF LIABILITY & COVENANT NOT TO SUE

(READ CAREFULLY BEFORE SIGNING AND BRING TO FIRST CLASS SESSION)

The undersigned hereby acknowledges that participation in off-site excursions, classes and recreational activities involves inherent risks of physical injury and assumes all such risks. The undersigned hereby agrees that for the consideration of Kennesaw State University allowing the undersigned to participate in off-site excursions, classes or recreational activities and, in connection therewith, making available to the undersigned for facilities, grounds, or personnel of the institution, the undersigned participant does hereby waive liability, release and forever discharge the institution and the Board of Regents of the University System of Georgia, its members individually, and its officers, agents and employees of and from any claims, demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, including death, resulting from my voluntary participation in or in any way connected with such off-site excursions, classes or recreational activities.

I further covenant and agree that for the consideration stated above I will not sue the institution, the Board of Regents of the University System of Georgia, its members individually, its officers, agents, or employees for any claim for damages arising or growing out of my voluntary participation in off-site excursions, classes or recreational activities.

I understand that the acceptance of this release, waiver of liability and covenant not to sue the institution of the Board of Regents of the University System of Georgia or any agent or employees thereof, shall not constitute a waiver, in whole or in part of sovereign or official immunity by said Boards, its member, officers, agents, and employees.

Further, I understand that this release, waiver of liability, and covenant not to sue shall be effective during the time period indication below while I am participating in activities sponsored by Kennesaw State University.

COURSE NAME _____ **DATES** _____

_____ **I authorize Continuing Education at KSU to share this information with the instructor(s). Please check.**

Signature: _____ Date: _____

Participant or Legal Guardian if participant under the age of 18.

Print Name: _____

Emergency Contact Name & Telephone Number:

Please list any special health problems/allergies/medications:

Human Subjects Document

Assumption of Risk & Consent to Procedures

General Information

During this course you will be participating in laboratory activities in which learning by students requires the use of human subjects as part of the training. As a part of these learning activities you will be asked to perform specific skills as well as be the subject of specific skills practiced by students. These learning activities will be conducted under the supervision of the course instructor.

Benefits

The activities have been selected because they are skills essential to the learning process and the faculty believes that realistic practice is essential for optimum learning.

Bloodborne Pathogen Exposure

It is important that you be aware that blood and other body fluids have been implicated in the transmission of certain pathogens, particularly Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV), the virus responsible for Acquired Immune Deficiency Syndrome (AIDS). In order to minimize risk of exposure to bloodborne pathogens, the student must agree to follow Standard Precautions guidelines as well as comply with regulations outlined in the OSHA Bloodborne Pathogen Standard.

Risks/Discomforts

Participation may create some anxiety or embarrassment for you. Some procedures may create minor physical or psychological discomfort. Specific risks are listed below.

Your Rights

You have the right to withhold consent and to withdraw consent after it has been given. You may ask questions and expect explanation of any point that is unclear.

LEARNING ACTIVITY	SPECIFIC BENEFIT	RISKS/DISCOMFORTS
Venipuncture using both evacuated tube system (ETS) and syringe system.	Student gains experience needed prior to performing procedures on actual patients.	Possibility of hematoma or bruising; slight, temporary pain with procedure; slight risk of temporary nerve inflammation; blood or body fluid exposure.
Skin puncture of the finger tip.	Student gains experience needed prior to performing procedures on actual patients.	Slight, temporary pain upon puncture; minimal possibility of infection (provided area is kept clean); blood or body fluid exposure.
12-lead ECG lead(s) placement and removal.	Student gains experience needed prior to performing procedures on actual patients.	Slight, temporary pain upon removal of lead(s); possibility of allergy to glue on lead(s); temporary discomfort during state of disrobe.

I have read the above Human Subjects Document. I acknowledge my understanding of the risks and benefits described. My questions have been answered. I agree to participate as a subject in the learning activities listed above.

Signature of Student

(Parent or Guardian if student is under 18 years of age)

Date

Printed Name: _____

Health History & Immunizations

This form must be completed and signed by your Healthcare Provider

Personal Information

NAME _____ DATE OF BIRTH _____

Immunization History

***** IF YOU HAVE TITERS, PLEASE ATTACH VALUES REPORT *****

TB TEST

***** Skin Test or Chest X-Ray must be negative. No older than 6 months *****

Date _____ Measurement of induration in millimeters _____

Chest X-Ray Date _____

Current treatment for latent TB, please indicate medication dose, frequency and duration _____

Provider Signature _____ Date _____

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap)

***** No older than 10 years *****

Date _____

TD Date _____ * If less than 2 years

MEASLES, MUMPS, RUBELLA (MMR)

***** Must have 2 immunizations OR Positive Titer *****

Date of Immunization #1 _____ #2 _____

Positive Measles Titer Date _____

Positive Mumps Titer Date _____

Positive Rubella Titer Date _____

HEPATITIS B

***** Must have 3 immunizations OR Positive Titer *****

Date of Immunization #1 _____ #2 _____ #3 _____

Positive Titer Date _____

VARICELLA

***** Must have 1 of the following *****

Date of Disease _____

Date of Vaccine #1 _____ #2 _____

Positive Titer Date _____

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

The student above is capable of performing duties as a Medical Assistant.

Healthcare Provider Signature _____ Date _____

Healthcare Provider Name (Print) _____

Address _____

Phone Number _____

Application Packet Checklist

Please return completed Application Packet to KSU. Incomplete packets will not be accepted.

1. Have you completed the online **Skills Assessment & Program Application**?
2. Did you fill out the **Student Information**?
3. Did you read and fill out the bottom section of the **Release, Waiver of Liability & Covenant Not To Sue**?
4. Did you read and fill out the bottom section of the **Human Subjects Document**?
5. Did you read, fill out, and sign the **Background Check Information**?
6. Did your Healthcare Provider fill out all sections of the **Health History & Immunizations**? If you have Titters, did you attach the values report?
7. Did you make a front/back copy of your **Current, personal Health Insurance card**?
8. Did you make a copy of your **Driver's License**?
9. Did you make a copy of your **Social Security Card**?

END OF APPLICATION PACKET