MOLLOY COLLEGE

Division of Continuing Education and Professional Development

C.T. Cross Training Program

Name____ Home Phone (____)_______________________

Address ____ Work Phone (____)_______________________

City ________________________St. _____Zip ________ E-mail___________________________________

NYS. License # ____

Expiration Date ________________________ Years of Experience ______________________

Name of Employer ____

Please indicate how you intend to complete the clinical component of the course:

____ I will be completing the clinical component at the facility that I am employed with (if this is the case, you do not need to take out separate malpractice insurance or complete the health forms).

____ I will be completing the clinical component through a Molloy clinical site (if this is the case you will need to provide malpractice insurance and complete the health forms on the following pages).

Professional Malpractice Policy # ____

Physical Exam: _______________________________ Date ____
(Completed or scheduled)

I certify that all information I have provided in this application is true and complete to the best of my knowledge.

Signature ____________________________________ Date:___________________________________

The completed forms can be mailed to:

Marc Fischer, MBA, LNMT, RT, CNMT
Continuing Education and Professional Development
Molloy College- PO BOX 5002
1000 Hempstead Avenue
Rockville Centre, New York 11571-5002

The forms may also be faxed to: 516-323-3560 or scanned and emailed to: conted@molloy.edu.

Registration Process:

You will be notified of your admission status to the course within 2 weeks of the receipt of your application. If you are accepted into the program you will be required to make a tuition deposit of $1,000 towards the total tuition of $2,500 within two weeks of your acceptance. The balance is due two weeks prior to the start of the course. A refund of the deposit will be made only if written notification of withdrawal is made 2 weeks prior to the start of the program. After this date, deposit will not be returned.

If you have any questions concerning the application or registration process, please call Molloy College Continuing Education and Professional Development at (516) 323-3558 or (516)-323-3550.

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Checklist

Physical (Please include:)

☐ Yearly physical exam (our form) by MD, Nurse Practitioner or Physician Assistant.

☐ Two Step Tuberculin Test (**if positive copy of chest x-rays results**).

☐ DT every ten years Diphtheria/Tetanus

☐ Evidence of Immunization: Measles, Mumps, Rubella, Chicken Pox **(copy of lab report)**

☐ Season Flu Vaccine

☐ Laboratory Print out of Results of Titres for:
- Rubeola
- Rubella
- Varicella
- Mumps

NB Equivocal results will require a repeat testing; values indicating non-immunity will require a vaccine for rubella and rubella

☐ Waiver Signed

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History/Physical Form

Name____ Home Phone (___) ______________________________

Address ______________________________________ Work Phone (___) ______________________________

City _______________________St. _______Zip ______ E-mail ____________________________________

Date Rec'd by Continuing Education ____________

Requires Annually: **(Must be done within 30 days of Physical)**

Two Step Tuberculin Test (PPD intradermal only) Date ___________ Result: _____________

Date ___________ Result: _____________

If positive, then a Chest X-Ray Date ___________ Result: _____________

<u>Required on Initial Physical Only:</u>

*Attach Lab Reports to this Form

Titre	Value	Date	Result	If Negative, <u>*Date*</u> *Vaccine Administered*
* Rubella	_________	_________	_________	_________________
* Varicella	_________	_________	_________	_________________
* Rubeola	_________	_________	_________	_________________
* Mumps	_________	_________	_________	_________________

Polio Tri-Valent Oral Series Date: ______________________ ☐ Seasonal Flu Vaccine________________

Diphteria/Tetanus
(DT) Series Date: _______________ Booster within ten years date: ________________________________

**Hepatitis B Vaccine: 1. Date ___________ 3. Date ___________

2. Date ___________ Follow-up Titre __________
(Recommended)

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Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been informed of the need to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Name (Print) ____

Student Signature ____ Date ____________________________________

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Student Waiver of Health Records

I, the undersigned, authorize release of information from my Student Health Record to affiliating clinical agencies.

Please Sign Below:

Student
Signature: ____ Date: ______________________

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History/Physical Form

I certify that (print name of student) ___________________________________ is in good health as determined by a recent physical examination of sufficient scope to ensure that he or she is free from health impairments which may be of potential risk to patients or other personnel or which may interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior. This individual is able to participate in clinical learning experiences as a student of Nursing.

Height: __________ Weight __________ B.P. __________ HCT: __________

Vision: __________ Hearing: __________ HGB: __________

U/A __________ WBC __________ Diff: __________

Allergies: _________________________ Provider Signature: __________________

Illnesses: _________________________ Provider Signature: __________________

Injuries: _________________________ Provider Signature: __________________

Restriction on Activity: _________________________ Provider Signature: __________________

Medications: _________________________ Provider Signature: __________________

**Disabilities: _________________________ Provider Signature: __________________

** Students with disabilities/restrictions are considered on an individual basis. Students must be able to meet program objectives.

____________________________________ ____________________________________

Name of MD, Nurse Practitioner or Physician Assistant (Stamp) Signature

____

Address Phone

Date: ___________