Cisco College Surgical Technology Program
Application for Admission and Student Health Record

Cisco College does not discriminate on the basis of race, color, creed, national origin, religion, age, gender, sexual orientation, political affiliation, or physical disability

Applications to Health Sciences Programs will **NOT** be considered if they are *incomplete*. Please check your application carefully and write legibly. ***Must use black or blue ink***.

Please Print or Type Application Date: _____

Name: _____
Last First Middle

Address: _____
Number and Street County City State Zip

Home Phone: _____ Alternate Phone: _____

Social Security #: _____-_____-_____ Date of Birth: _____

Student ID#: _____-_____-_____.

E-mail: _____

Have you made prior application to any Cisco College Health Sciences Program? ___Yes ___No

If yes, which program? _____

When (approximate date): _____

It is the student's responsibility to:

Return this application to **Jennifer Mazey** at the Abilene Education Center of Cisco College. It may be returned by mail or in person. **PLEASE DO NOT FOLD**.

Abilene Education Center mailing address: 717 E. Industrial Blvd, Abilene, Texas 79602. Should you need further assistance, please call 325-794-4436 or 325-794-4575 or visit our website at www.cisco.edu.

Please note: Students mailing address must be current with the Health Science Department as well as the Admissions and Records office.

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Please provide the following information:

Education

School	Name/Location of School	No of Years Completed	Graduate: Yes/No	Field Major	# Credits or Degree earned
High School		9 10 11 12			
College/University		1 2 3 4			
Graduate School		5 6 7 8			
Business, Technical, GED, Other					

If testing was completed at another school, please submit a copy of the documentation with your application.

List any licenses or certificates held (i.e. LVN, EMT, CPR): _____

_____

Employment Record: **Start with the most recent employment and list all jobs you have held. Additional information may be placed on a separate sheet of paper and attached**

From	To	Employer	Address	Telephone
Job Title		**Responsibilities**		
Supervisor/Title				
Reason for Leaving			**Hourly Salary** Start: _____ End:_____	

From	To	Employer	Address	Telephone
Job Title		**Responsibilities**		
Supervisor/Title				
Reason for Leaving			**Hourly Salary** Start: _____ End:_____	

From	To	Employer	Address	Telephone
Job Title		**Responsibilities**		
Supervisor/Title				
Reason for Leaving			**Hourly Salary**	

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	Start: _____ End:_____

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May we contact the employers listed above if applicable? _____Yes _____No

For the purpose of verifying education, professional and employment records, please indicate any other names by which you have been known, other than the name under which you are applying?

_____

Note:

On the following page, you will find a *Student Health Record*. The SRGT Application, Student Health Record, and proof of immunizations must be completed, signed, and submitted with your application. Incomplete applications, as reflected by missing items from the checklist, will **NOT** be considered for selection into the program.

This application may not reflect recent program changes. Please access the most up-to-date information on the program's website at www.cisco.edu

I, _____,(print name) hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or falsification of information is cause for denial of admission or expulsion from the college. I understand that the Admissions Committee of the Cisco College Surgical Technology Program will review the information contained in this application.

_____ _____

Student Signature ***Date***

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DIRECTIONS: Please print in ink (blue or black) or type before going to your physician for examination. Be sure to answer all questions fully. Information will not be released to unauthorized persons without your written consent. The student ***must*** submit the completed "Student Health Record" ***prior to program start***. If requesting accommodations, you must provide appropriate medical, psychological, and/or psychiatric documentation to support this request.

***A copy of immunization record and/or titer must be attached*.**

SECTION I (to be completed by student)

Name _____
Last First Middle Initial

Home Address _____
(Street) (City) (State) (Zip)

Social Security Number _____ Birth Date _____

Telephone _____
(Home) (Cell)

Section II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner) Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height _____ Weight _____ Blood pressure _____

Corrected Vision: Right 20/ _____ Left 20/_____

Hearing: Right: _____Normal _____Impaired Left: _____Normal _____Impaired

A. Does the student have any abnormalities in the following systems? (Give dates, description of abnormality and treatment of ALL findings. See below)

System	Yes	No	System	Yes	No
Eyes			Metabolic/Endocrine		
Ears, Nose, Throat			Genitourinary		
Cardiovascular (including murmurs)			Skin		
Neurological			Immunological		
Respiratory			Psychiatric		

B. If you have answered "yes" to any item in "**A**" above, please complete the following: (Record additional information on back of this page).

Date	Diagnosis	Treatment

Please list any other medical conditions not addressed above: _____

_____

Please list all medications that you are currently taking: _____

_____

C. ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE SURGICAL TECHNOLOGY PROGRAM

The following standards are considered essential criteria for participation in the Surgical Technology Program. SRGT applicants must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the SRGT Program. For acceptance into or retention in the SRGT Program after admission, all applicants with or without accommodations must:

- Possess sufficient visual acuity to independently read and interpret the writing of all size.
- Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs with the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc.
- Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment and instrumentation, and perform other skills required in meeting the needs of the surgical patient.

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Print Name of Physician, Physician Assistant, or Nurse Practitioner ***Date***

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner ***Date***

The following are mandatory immunizations/tests required for acceptance into the Surgical Technology Program.

Students must submit <u>physician's documentation</u> of required immunization record or titer or test with the application.

- **Proof of Varicella (Chicken Pox)** immunity as shown by (a) *physician <u>documented</u> history of disease*, (b) documentation of two immunizations, OR (c) a serum titer confirming immunity
- **Proof of Hepatitis B Vaccination** (a) first two doses administered (the third vaccination in the series must be completed by the end of the provisional semester) OR (b) a serum titer confirming immunity
- **Proof of MMR vaccination** – Students must provide proof that he/she received at least two Measles vaccinations, one Mumps vaccination and one rubella vaccination OR (a) serum titer confirming immunity of Measles, Mumps, Rubella (b) proof that student was born prior to January 1, 1957 or immunity as shown, (c) physician documented history of disease
- **Bacterial Meningitis Vaccination** (if applicable)
- **Proof of Tetanus-Diphtheria Pertussis Vaccination** within last 10 years.
- **Proof of negative Tuberculin Skin Test within the past year**