

EKG Monitor Tech CHECKLIST

- ☐ **Online Application** Once you complete the online application, print it prior to submitting.
- ☐ **Acknowledgement Form** Read and sign.
- ☐ **High School Transcript/GED** Provide official proof of HS graduation. Can be submitted electronically, mailed, or included in a sealed envelope in your packet.
- ☐ **Immunization Form** A healthcare provider must complete this form.
- ☐ **Substance Free Attestation** Read & sign.
- ☐ **Photocopy of ID** Provide a copy of your driver's license or government-issued photo ID.
- ☐ **\$25 Application Fee** We accept credit/debit card, check, or money order. No cash is accepted.
- ☐ **If applicable to you** Proof of permanent residency if not born in the U.S.
- ☐ **Submit your packet** Place all items in a manila envelope. Deliver in person or mail to 1919 Frankford Ave., Lubbock, TX 79407. Partial packets will not be accepted.

Covenant School of Nursing- Extension Program Acknowledgement Form

Legal Name (print): _____
(last) (first) (middle) (maiden)

Other last names used: _____

Date of Birth _____ Social Security No. _____ - _____ - _____
(mm/dd/yyyy)

Criminal Background Check

I authorize Covenant School of Nursing to obtain a criminal background check as part of my admission process, understanding that Covenant School of Nursing - Certified Patient Care Technician Program will rely upon information it obtains. I understand that information reported through a criminal background check could be cause for non-admission to Covenant School of Nursing.

Legal Name (print) _____ Signature _____

Have you ever been convicted of a crime (please circle your answer, failure to accurately answer will result in denial of your admission to CSON)? YES or NO

Do you have any criminal charges pending (please circle your answer, failure to accurately answer will result in denial of your admission to CSON)? YES or NO

Functional and/or Learning Disabilities

I understand it is my responsibility to notify Covenant School of Nursing of any functional disabilities which might interfere with my learning and performance as a patient care technician student and necessitate special accommodations while in school. Furthermore, I understand that if I require special accommodations because of disability, I must request in writing such consideration and submit a current letter from an appropriate licensed professional describing the nature of the functional limitation and specific accommodations needed while a student at Covenant School of Nursing.

Legal Name (print) _____ Signature _____

Release and Hold Harmless

I hereby release from any liability all persons and entities who provide information concerning my competence, ethical conduct, character, and other information regarding my qualifications for admission to Covenant School of Nursing- Certified Patient Care Technician Program. I further fully release and forever discharge Covenant School of Nursing, Covenant Health System, and their servants, agents and employees for their use of and reliance upon any such information obtained and hereby indemnify and hold them harmless from any liability or loss whatsoever, including court costs, attorney's fees, expenses and payment of claims or judgments, which may result from their use of or reliance upon such information

Legal Name (print) _____ Signature _____

By signing below, I acknowledge that I have read and understand the CSON Certified Patient Care Technician application requirements.

Applicant Signature: _____ Date: _____

What is the Immunization Verification Form? If an applicant is selected to enter our program, this allows our office to process tentatively accepted students more efficiently.

Where can I go to get this form filled out? Your healthcare provider's office, the Health Department or the Student Health office of your current college. Explain to them that you are applying for a nursing program and are required to have this form completed by a healthcare provider. You might need to gather all shot records and take them to the healthcare provider, if they do not have access. The healthcare provider will verify the information you provide them, by filling out the Immunization Verification Form. It must be completed and signed by a licensed Health Care Provider. Examples are a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility.

Where can I get a copy of my immunization records? Your healthcare provider's office, the Health Department or the Student Health office of the college you are currently attending.

Can I just turn in my shot record? No, this form is required for the application process. A shot record will not be accepted in place of this form.

What if I do not have any documentation of my shot records? If you have no documentation at all, you can have titers drawn for the immunizations that you do not have documentation for. This is a blood draw to check for immunity to each vaccine, and must be done at a healthcare facility or lab.

Please reach out to the Admissions office with any questions!

Applicant Name: _____
DOB: _____
Last 4 of SS#: _____

To be completed by a Physician or Other Health Care Provider. Please do not sign the compliance form unless the named person has proper vaccines or immune test. Note: All vaccines administered after September 1, 1991 shall include the MM/DD/YY that each vaccine was given.

Immunization		Option #2	Obtain a Titer "blood draw" from Dr. Office showing "positive" for antibodies/immunity Note: if negative, a booster or vaccine is required.
Measles (Rubeola)*: Two doses of measles-containing vaccine on or after January 1, 1968.	Date#1 _____ Date#2 _____ (mm/dd/yy) At least 30 days apart	OR Serologic test positive for measles antibody	Date _____ (mm/dd/yy) Results _____
Mumps: One dose of mumps vaccine on or after January 1, 1957.	Date#1 _____ Date#2 _____ (mm/dd/yy)	OR Serologic test positive for mumps antibody	Date _____ (mm/dd/yy) Results _____
Rubella: One dose of rubella vaccine on or after the first birthday.	Date#1 _____ Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible. **Must include date of test collection. **	OR Serologic test positive for Rubella antibody	Date _____ (mm/dd/yy) Results _____
Varicella: Two doses of varicella vaccine. History of Disease is not accepted. Must have Vaccine or Titer.	Date#1 _____ Date#2 _____ (mm/dd/yy) Doses must be 30 day apart	OR Serologic test positive for Varicella antibody	Date _____ (mm/dd/yy) Results _____

Hepatitis B: (3 doses) "PreHevbrio only 2 does required" Date#1 _____ Date#2 _____ Date#3 _____ (mm/dd/yy)	OR	Serology/Titer (lab work results) Date _____ (mm/dd/yy) Results _____ Must include date of test collection and results; It is highly recommend that applicants complete the lab work.
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Note: An accelerated dosing schedule with Twinrix vaccine (Hepatitis A and Hepatitis B recombinant) may be an option to meet Texas DSHS requirements for Hepatitis B immunization.

Tdap (tetanus, diphtheria, pertussis"whooping cough") One dose of Tdap within the last 10 years. Date _____ (mm/dd/yy)
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Bacterial Meningitis: For those that are 22 years old or younger.	MCV-4 Date _____ (mm/dd/yy)	OR	MPSV-4 Date _____ (mm/dd/yy)
To be completed and signed by a physician or other licensed Health Care Provider. Example a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility. Signature: _____ Signature validates all information on this form. Date: _____		Name of Dr./Office: _____ Address: _____ City: _____ State: _____ Phone: _____	

**Substance-Free Attestation and
Acknowledgement of Substance-Free Workplace Policy
Covenant School and Nursing and Radiology**

Consistent with our mission and values, this healthcare facility is committed to providing a workplace free of illegal drug use and unauthorized prescription drug use.

Pursuant to federal law and rules promulgated by the U.S. Department of Drug and Alcohol Enforcement, the facility must obtain information from candidates about past illegal drug use and unauthorized prescription drug use as part of the facility's comprehensive student drug screening program.

Within the past three (3) years, have you ever knowingly used any narcotics, amphetamines, or barbiturates, other than those prescribed to you by a physician?

☐ Yes

☐ No

Please provide details:

☐ By my signature below, I attest that I am not currently using any drug whose use is prohibited or restricted by federal law, including but not limited to marijuana/THC (including medically prescribed marijuana), cocaine, opiates, amphetamines, phencyclidine (PCP) hallucinogens, methaqualone, barbiturates, narcotics, and any other substance included in schedules I-V, as defined by Section 812 of Title 21 of the United States Code; nor am I taking any prescription medications in an unauthorized manner.

☐ Further, by my signature below, I agree to abide by the facility's Substance-Free Workplace Policy (Substance_Free_Workplace_Policy.pdf) that prohibits any drug use described above throughout my attendance at the Covenant School of Nursing or Radiology. I understand that any violation of the policy will be grounds for corrective action, up to and including immediate termination.

Name: _____

Date: _____