EKG Monitor Technician Application Checklist

Application packets will not be accepted unless ALL documentation is complete & included

	Application Checklist – This form, completed & signed
	Online Application – Once you complete the online application, please print it and include in this packet
	Acknowledgement Form – Complete & sign
	Official High School Transcripts, GED verification or VOE
	Immunization Verification Form –Completed fully by a licensed healthcare provider
	TB Questionnaire – Completed by you
	Covid-19 Vaccine card or Declination Form
	Photocopy of your Driver License or Government issued ID
	$25 Application fee – Payable via credit/debit card, money order or check
	If applicable: • Proof of Permanent residency for applicants not born in the USA
	Place all items in a **Manila Envelope** and turn in in-person or by mail: Covenant School of Nursing, 1919 Frankford Ave, Lubbock TX 79407

Questions? Contact Lauren Bruington, Admissions Officer ☺ (806) 725-8902 - lauren.bruington@covhs.org

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:** _____________________

Covenant School of Nursing
1919 Frankford Ave
Lubbock, TX 79407

Covenant School of Nursing

What is the Immunization Verification Form? If an applicant is selected this allows our Employee Health Office to process tentatively accepted students more efficiently.

Where can I go to get this form filled out? It is the applicant's responsibility to contact their healthcare provider or a healthcare provider of their choice. Explain to them that you are applying to a nurse aid program and are required to have this form completed by a healthcare provider. The applicant must gather all their shot records and take to the healthcare provider of their choice. The healthcare provider will copy over the information you provide them.

To be completed and signed by a physician or other 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.

What if I cannot get this form completed by the deadline? This form is a required document for the application process. If you are having difficulty getting this form completed, please email in a timely manner Lauren Bruington at lauren.bruington@covhs.org. If you are unable to get this form completed by the deadline, please check our website to apply for the next application cycle.

Where can I get a copy of my immunization records? Here are some recommendations as to where to look for your immunization/vaccine records.

Check with your medical provider/clinic and schools that you have attended.

Can I just turn in my shot record? No, this form is a required form for the application process.

What if I do not have any documentation of my shot records? If you have no documentation at all, you can have the serologic test/s (lab work) for those immunizations that you do not have documentation for or you may get the immunizations again.

Will additional documentation of immunizations be required if selected? No additional requirements will be required once the applicant is accepted.

If you have questions, please email the Admission Officer Lauren Bruington at lauren.bruington@covhs.org

Covenant School of Nursing

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"		Serology/Titer (lab work results)
Date#1__________ Date#2__________ Date#3__________ **(mm/dd/yy)**	**OR**	Date__________ **(mm/dd/yy)** Results__________ **Must include date of test collection and results; It is highly recommend that applicants complete the lab work.**

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)**

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:

Providence St. Joseph Health

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name: ______________________________________ **Date of Birth:** ________________ **Date** ______________
Last First Middle

Dept: _______________________________________ **Home/Cell Phone #:** ___________________________________

☐**Caregiver/Applicant** ☐**Volunteer** ☐**Other:** ____

DO YOU CURRENTLY HAVE SYMPTOMS OF:		**If yes, please explain**
1. Persistent and/or productive cough for more than three weeks?	☐Yes ☐ No	
2. Cough for more than one week following confirmed TB exposure?	☐Yes ☐ No	☐N/A
3. Prolonged low grade fever associated with cough for more than 1 week?	☐Yes ☐ No	
4. Blood present in sputum?	☐Yes ☐ No	
5. Unexplained night sweats (unrelated to menopause)?	☐Yes ☐ No	
6. Unusual fatigue for more than two weeks?	☐Yes ☐ No	
7. Loss of appetite for more than two weeks?	☐Yes ☐ No	
8. Unexplained weight loss of five pounds or more?	☐Yes ☐ No	
CURRENT HEALTH STATUS:		**If yes, please explain**
9. Do you have an acute viral infection or febrile illness?	☐Yes ☐ No	
10. Have you had a live-virus vaccine in the past four weeks?	☐Yes ☐ No	
11. Are you on or planning to begin immunosuppressive therapy or treatment for: diabetes, human immunodeficiency virus (HIV) infection, organ transplant recipient, undergoing radiation therapy, chemotherapy, treatment with a TNF-alpha antagonist (e.g., Infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15 mg/day for >1 month) or other immunosuppression medication? (*)	☐Yes ☐ No	
HISTORY:		**If yes, please explain**
12. Have you lived or visited (more than one month) in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand and those in northern Europe or Western Europe). (*)	☐Yes ☐ No	
13. Have you had unprotected close contact with someone who has had infectious TB disease in the past 12 months or since your last TB test? (*)	☐Yes ☐ No	Relationship:
14. Have you received the BCG vaccination?	☐Yes ☐ No	
15. Have you ever had a positive TB skin or blood test?	☐Yes ☐ No	Date:
16. Have you had a chest x-ray related to TB?	☐Yes ☐ No	Date:
17. Have you ever been treated with TB medications?	☐Yes ☐ No	

Please note: HIV infection and other medical conditions may cause a TB test to be negative even when TB infection is present. Persons with HIV infection and certain other medical conditions that may suppress the immune system are at significant risk of progressing to TB disease if they have TB infection. If you have HIV infection or other medical conditions that may suppress the immune system, discuss your risk of TB with your primary care provider.

To my knowledge, the above information is correct. I consent for an IGRA (TB) blood test, and/or chest x-ray, if applicable.

Applicant/Caregiver Signature: ___________________________________ **Date:** _______________________

For Clinic Use Only

(*) Risks: if any one question is marked yes, refer back to TB algorithm.

***(!)* Any questions 1-8 marked positive refer to TBQ Scoring Grid Standard Work.**

Caregiver Health Nurse Review: Based on current TB algorithm, I have reviewed the above and recommend:
☐IGRA ☐TST ☐Symptom review only

Caregiver Health Nurse Name (print): ______________________ Signature: ____________________ Date: __________

IGRA: Draw Date: ________Review Date: ________ IGRA Results: ☐Negative ☐ Positive

IGRA: Draw Date: ________ Review Date: ________ IGRA Results: ☐Negative ☐ Positive

Follow-up Action: ☐ No further follow up needed CHN Name: ______________________

CXR ordered; Date: _________ Results: ☐Negative ☐ Positive CHN Name: ______________________

For known history of positive TB test: TST on file? ☐Yes ☐No Date: __________ If yes, IGRA drawn? ☐Yes ☐ No

IGRA on file? ☐Yes ☐ No Date: ______ CXR on file? ☐Yes ☐ No Date: __________ Results: ☐ Neg ☐ Pos

Providence
Providence SWEDISH | PROVIDENCE Health & Services | CovenantHealth | KADLEC | pacific medical centers

CAREGIVER HEALTH SERVICES

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

COVID-19 Declination Form 2024-2025

Providence St. Joseph Health and its family of organizations requests caregivers participate in the COVID-19 vaccination process by either being vaccinated or completing a written declination.

LEGAL NAME:______________________________ DOB: ________________ EMPLOYEE ID#______________

CAMPUS/SITE:_________________________DEPT:________________________PHONE:_________________

IF NOT EMPLOYED BY PROVIDENCE, CHECK ONE:

☐ Medical Provider ☐ Volunteer ☐ Agency/Contractor ☐ Student ☐ Other ____________________

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- *COVID-19 can cause severe illness or death and you can continue to have long-term health issues after COVID-19 infection. The level of protection people get from a COVID-19 infection may vary depending on how mild or severe their illness was, the time since their infection, and their age.*
- *Getting a COVID-19 vaccine can provide added protection for people who have already had COVID-19.*
- *Getting a COVID-19 vaccine is a safer and more dependable way to build immunity than getting sick with COVID-19, as vaccination causes a more predictable immune response than an infection with the virus that causes COVID-19.*
- *COVID-19 vaccines are recommended for healthcare workers because of the potential for workplace exposure and because of the vulnerability of the patients and residents they care for.*
- *COVID-19 vaccines help prevent severe illness, hospitalization, and death. Unvaccinated people are more likely to get COVID-19 and much more likely to be hospitalized and die from COVID-19, compared to people who are up to date with their COVID-19 vaccinations.*
- *COVID-19 vaccination is recommended for people who are pregnant, breastfeeding, or trying to get pregnant, as well as people who might become pregnant in the future. COVID-19 vaccination during pregnancy helps prevent severe illness and death and helps protect babies younger than 6 months old from hospitalization.*
- *Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.*
- *Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.*
- *Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations. Serious side effects are rare but may occur.*
- *I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.*
- *I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.*

Resources for future reference:
COVID-19 Vaccine Frequently Asked Questions | COVID-19 | CDC
Myths & Facts About COVID-19 Vaccines | COVID-19 | CDC
Healthcare Worker Vaccination is Important for Respiratory Virus Season | Blogs | CDC

I am declining the COVID-19 vaccine because of:

☐ My Licensed independent practitioner-documented allergy or medical contraindication to the components of the vaccine

☐ My religious beliefs, including my sincerely held ethical or moral beliefs

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM

I, ____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the **legal equivalent** of my manual/handwritten signature and I consent to be legally bound to this agreement.

Signature:____ **Date:**______________________