American Academy of Healthcare, LLC
Providing Excellence in Healthcare Education

4822 Albemarle Road
Suite 110
Charlotte, NC 28205
Phone: 704-525-3500
Fax: 704-536-6675

Phlebotomy
Admission Requirements

1. **Only provide <u>one</u> original transcript of:**
   1. **High School Transcript**
   2. **GED Transcript; or**
   3. **College Transcript**

2. **Driver's License or State ID**

3. **Social Security Card (non-laminated)**

4. **Physical Examination ($40.00, can be done on premises)**

5. **Criminal Background Check ($20.00, done on premises)**

6. **CPR Certification ($40.00, done on premises during class)**

7. **TB Test ($20.00), (done on premises prior to clinical rotation)**

8. **Verification of the Immunization:**
   (must have immunization verification form completed and attached to application)

   - **Tetanus or Diptheria (within 10 years)**
   - **Varicella (Chicken Pox) (positive history or titer documented)**
   - **Rubella or positive titer (German Measles)**
   - **Rubeola (Measles) 1 dose and (2 doses after 1st birthday for any person born after 1957) or positive titer**
   - **Mumps (1st dose for any person born on or after January 1, 1957) or positive titer**
   - **PPD Skin Test (TB) (have one done each year)**
     - **Chest X-Ray and INH if PPD is positive**
     - **Chest X-Ray if known to be PPD positive in the past**

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Enrollment Agreement

Name: ____

Address: ____

City: ____________________ State: __________ Zip: _______________

DOB: ____________________ Social Security #: ______________________

Home Phone #: ____________________ Cell: __________________________

Alternate Contact #: ____________________ Emergency #: ____________________

E-mail Address: ____

Program Information:

_______ Nursing Assistant I
_______ Nursing Assistant II
_______ Medication Aide
___√___ Phlebotomy
_______ Wound Care Program
_______ Maintaining a Home Care Agency
_______ Telemetry Technician
_______ Medical Assisting
_______ Dialysis Technician

Start Date: ____________________ End Date: ____________________

A class schedule for which you enrolled (meets on day of week): ______________________

A ***Certificate of Completion*** will be awarded at the end of the program and successful students will be recommended to take the National Phlebotomy Exam.

Education:

SCHOOL NAME AND ADDRESS	START MO/YR	END DATE MO/YR	DID YOU GRADUATE?	DEGREE
______________________ ______________________				

College/University:

SCHOOL	START MO/YR	END DATE MO/YR	DID YOU GRADUATE?	DEGREE
______________________ ______________________				

Other Education:

____

Other Certifications:

____

Employment History: (most recent employment first)

Employer Name and Address	START MO/YR	END DATE MO/YR	POSITION
____________________ ____________________			
____________________ ____________________			

Fees and Charges:

You are responsible for paying the following Fees and Charges:

- Registration Fee $ **26.06**
- Tuition $ **1285.00**
- Text Book $ **85.00 (mandatory purchase)**
- Criminal Check $ **20.00 (mandatory prior to clinical rotation)**
- Uniform $ **20.00 (mandatory purchase)**
- TB Test $ **20.00 (must have within the last year)**
- Drug Screen $ **40.00 (mandatory prior to clinicals)**
- CPR $ **40.00 (mandatory within 2 years, or if expired)**

Total $ **1536.06 (requirements will be deducted)**

Total charges for Registration and the Phlebotomy Technician Course is due and payable on or before the first day of class, if you choose to make a payment plan, you are still responsible to complete the payment even if you did not complete the program.

Terms and Understanding:

As a Student of American Academy of Healthcare, I understand that:

1. The school does not guarantee employment following graduation.
2. The school deserves the right to terminate a student's training for failure to abide by the Attendance Policy, failure to maintain satisfactory academic progress, failure to abide by the school rules and regulations and for other reasons as detailed by the school catalog.
3. All fees such as tuition, uniforms, stethoscopes, books, CPR and other miscellaneous items are to be **paid prior to clinical rotation in a facility**, _________ (Initials) or the school deserves the right to terminate a student's training for failure to abide by the Payment Policy. ________ (Initials)

4. The textbook is provided by the school and I am paying for it under the heading textbook, all other materials that I will use in the lab and in the process of learning does not belong to me and should not be removed from the classroom.
5. The school does not guarantee the transfer of credit to any other institution.
6. **Any notification of withdrawal or cancellation must be in writing.**
7. This agreement is legally binding instrument when signing by you and accepted by the school. Your signature on this agreement acknowledges that you have been given reasonable time to read and understand it and that you have been given the school catalog including a description of this program, including all material facts concerning the school and the program of instruction which are likely to affect your decision to enroll.

Students Right to Cancel:
You may cancel this enrollment agreement for the school at any time up to the first day of class. If you cancel this agreement, any payment you have made will be refunded to you within 60 days. To cancel the enrollment agreement for the school you must mail or deliver a signed and dated copy of the cancellation notice or any written notice to the school at its' official address. For all other refunds, please see the refund policy.

Acknowledgement:
Do not sign this contract before you read it or if it contains blank spaces. You are entitled to an exact copy of the contract that you sign. Keep it to protect your legal rights.

My signature certifies that I have read, understood and agreed to my rights and responsibilities, that the institution's cancellation and refund policies have been clearly explained to me and that I have a copy of this agreement.

I hereby accept this agreement with the school.

______________________________ ______________________

Student Signature Date

Return the following items:

***Completed Application**
***Student Interview Form**
***Physical Examination**
***$25 Non-refundable Registration Fee**
***Background Consent Form**
***Immunization Record**
***Driver's License (Color Copy)**
***Social Security Card (Color Copy)**

MAIL TO:
American Academy of Healthcare, LLC
4822 Albemarle Road
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Accepted Forms of Payment
Cash
Money Order

NO CHECKS

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STUDENT ACKNOWLEDGEMENT

Name: ______________________ Date: ______________

I hereby acknowledge that I have received the American Academy of Healthcare Orientation Policy Manual and I have reviewed the policies in this booklet with the Instructor assigned.

- ☒ Attendance and Uniform Policy
- ☒ Privacy Acknowledgement and Non-Disclosure
- ☒ Competency Evaluation Skills Testing Procedures

____
Initials

I have been given the opportunity to ask any questions needed to clarify the information contained within. I also understand that I may request additional information or explanation at any time while I am a student with American Academy of Healthcare.

____
Initials

I also understand that all students fees have to be paid in full prior to clinical rotation. If my clinical file is incomplete prior to clinical rotation, I will not be attending the rotation at the assigned facility and will not be able continue in the program.

- ☒ Immunization Record
- ☒ TB Results
- ☒ Hepatitis B/Flu Declination Form
- ☒ Physical Examination
- ☒ Request, Authorization, Consent and Release for Background Check
- ☒ Criminal Background Check

____
Initials

I also understand that if any part of my student file is incomplete at the time of completion of the course, I will not receive Transcripts and/or a Certificate of Completion.

- ☒ Education Criteria
- ☒ Driver's License
- ☒ Social Security Card
- ☒ CPR Certification
- ☒ Quizzes/Final Exam/Mock Skills Exam

____
Initials

______________________ ______________
Student Signature Date

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Attendance Policy

All students are expected to attend required class, laboratory and related experiences, show evidence of preparation for learning and activity and be punctual.

Students must complete **210.0 hours** which includes **110.0 hours** (one hundred and ten hours of classroom) instruction/skill practicum and **100.0 hours** (one hundred hours of clinical) experience in an approved lab, physician's office, facility or hospital as approved by the program.

Absences should occur only in situations of personal illness, immediate family illness, military leave or death. It is the responsibility of the student to arrange for a make up which is at the discretion of the Program Director.

Excessive absences – more than sixteen hours will result in failure to meet program requirement and the student may be asked to withdraw or join the next class. A Physician's verification for illness may be required at the program director's discretion.

Uniform Policy

American Academy of Healthcare, LLC believes that proper dressing is essential for the student to present themselves in a professional manner to promote a positive environment. Therefore, students are expected to dress in an appropriate and acceptable manner for class, for clinical and any activity related to training. Students are required to wear ID badges at all times while at the academy for clinical rotation.

CLINICAL:
Students will wear red-colored scrub uniforms with natural or white hose for women and white socks for men. White or red-colored crew neck tee shirt or white or red-colored mock turtle necks may be worn under the scrub tops for warmth. White lab coats or jackets may also be worn. White or black shoes/tennis shoes and name badge.

No visible body piercing is allowed other than earrings. Limited jewelry, earrings are to be only small tack or small hoop. Artificial nails or nails that are long **may not** be worn by any student who provides direct resident/patient care.

____________________________ ________________
Signature Date

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PRIVACY ACKNOWLEDGEMENT AND NON-DISCLOSURE AGREEMENT

The facility is committed to protecting the privacy of all Residents/Patients and protecting the confidentiality of their health care information. The following specific principles are applicable to all of the facility employees, independent health care professionals involved in the care of Residents at the facility, volunteers, students, faculty, vendors and contractors regardless of their job classification or position.

While working with Residents at/or the facility, I realize that I may have access to/or become aware of confidential Resident medical information, whether or not I am directly involved in providing care to that Resident. I understand that I must keep this information n the strictest of confidence. As a condition of my employment or work at the facility, I agree that I:

- Will not verbally or in any written form disclose confidential Resident information to any unauthorized person.
- Will not permit any unauthorized person to examine or make copies of any Resident's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at the facility.
- Will not examine, use, or disclose confidential Resident medical information except as needed to perform the duties of my job.
- Will not knowingly include or cause to be included in any record or report, a false, inaccurate, or misleading entry.
- Will not remove or copy any record or report from the office where it is kept except in the performance of my duties.
- Will report any violation of this policy.

If I have access to computerized information or programs at the Nursing Home, I understand that the information accessed through all facility information systems contains sensitive and confidential Resident care, business, financial and Nursing Home employee information that should only be disclosed to those authorized to receive it. I commit to:

- Respect the ownership of proprietary software, by not making any unauthorized copies of software even when the software is not physically protected
- Respect the finite capability of the systems and limit my own use so as not to interfere unreasonably with the activity of other users.
- Respect the procedures established to manage the use of the system.
- Prevent unauthorized use of any information in files maintained, stored or processed by the facility.
- Not operate any non-licensed software on any computer provided by the facility. Not utilize anyone else's authentication code or device in order to access any of the facility system.
- Respect confidentiality of any reports printed from any information system containing Resident/member information and handle, store and dispose of these reports appropriately.
- Not release my authentication code.
- Understand that all access to the system will be monitored.
- Understand that my computer system privileges hereunder are subject to periodic review, revision and if appropriate renewal.

I understand that a violation of this agreement may result in corrective action up to and including discharge or termination of my student enrollment at American Academy of Healthcare, LLC and that my obligations under this agreement will continue after termination of my student enrollment.

By signing this, I agree that have read, understand and will comply with the facility's policies concerning confidentiality of information and use of computerized information systems and the statements made in this Agreement.

____________________________ ________________
Student Signature Date

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Student Interview Form

Date: ______________________

Student: ____

1. What do you think it takes to be a good Phlebotomy Technician?

____

____

2. What are (3) three words your friends would use to describe you?

________________ ________________ ________________

3. Give me an example of a time when you had to learn something new i.e. task or procedure. How did you learn the new task or procedure?

____

____

4. Describe your best learning experience. What made the experience a good one?

____

____

5. Where do you see yourself in 3-5 years?

____

____

Results of Interview:

☐ **Eligible for Enrollment** ☐ **Not eligible for Enrollment**

☐ **Other** ____

________________________________ ________________

Representative Signature **Date**

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EMERGENCY NOTIFICATION INFORMATION

Emergency Contact: ____

Address: ____ Apt No: ___________

City: __________________________________ State: _________ Zip: __________

Phone Number: [____ ____ ____] ____ ____ ____ - ____ ____ ____ ____

HOSPITAL PREFERENCE:

ALLERGIES:

NEW ADDRESS INFORMATION

Address: ____ Apt No: ______________

City: ______________________________ State: ______ Zip: _________________

Phone Number: [____ ____ ____] ____ ____ ____ -____ ____ ____ ____

Mobile Number: [____ ____ ____] ____ ____ ____ -____ ____ ____ ____

Pager Number: [____ ____ ____] ____ ____ ____ - ____ ____ ____ ____

Fax Number: [____ ____ ____] ____ ____ ____ - ____ ____ ____ ____

Other Contact Number: [____ ____ ____] ____ ____ ____ -____ ____ ____ ____

E-Mail Address: ____

Contact Name: ____

Phone Number: [__ __ __] __ __ __ - __ __ __ __

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Immunization Record

Name: ____ DOB: ______________________

Social Security #: (last 4) ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Proof of Immunization is required for admission into any Health Education Program that includes a Clinical Experience.

☐ **Hepatitis B** (series must have been completed)
Date(s) of Immunization:

1. _______________________ 2. ______________________ 3. ______________________

☐ **Measles, Mumps, Rubella** (individuals born before 1957 are not required to have proof of MMR Immunization)
Date(s) of Immunization:

1. _______________________ 2. ______________________

☐ **Tetanus** (within the last 10 (ten) years
Date of last Booster: _____________________________

☐ **Tuberculin Skin Test** (PPD) within the last year:

Date given: _______________ Date read: ______________ Results: _____________

Alternative: Chest X-Ray within the last 5 years

Date given: _______________ Date read: ______________ Results: _____________

☐ **Varicella** (Chicken Pox)
Date(s) of Varicella Immunization:

1. _______________________ 2. ______________________ 3. _____________________

Alternative: History of disease or Positive Titer Results

History of Disease:

Date: _________________ Date of Titer: _________________ Results: ___________________

____ ___________________________
Signature of Examining Medical Professional Date

____ ___________________________
Print Name of Examining Medical Professional (MD, PA or NP) Telephone Number

____
Address City State Zip

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HEPATITIS B AND FLU DECLINATION STATEMENT

THIS STATEMENT is not a waiver.

I UNDERSTAND that due to my educational exposure to body fluids, blood or other potentially infectious materials or substances I may be at risk of acquiring Hepatitis B Virus (HBV) infection.

I UNDERSTAND that by declining the HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I UNDERSTAND I can obtain the Hepatitis B vaccination from my physician in the future if I continue to have educational exposure to body fluids, blood or other potentially infectious materials or substances.

I UNDERSTAND if I remain educationally at risk and I want to be vaccinated with Hepatitis B vaccine, as an active American Academy of Healthcare student I can receive the vaccination series from my physician.

MY SIGNATURE also acknowledges that I do not have a known sensitivity to yeast or a previous reaction to the vaccine that is known.

My affiliated health facility, American Academy of Healthcare, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.

Influenza vaccination is recommended for me and all other healthcare workers to protect our patients from influenza disease, its complications, and death.

If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza disease to patients in this facility.

If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.

I understand that I cannot get influenza from the influenza vaccine.

The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, my coworkers, my family, my community.

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

____

____

____
Print Name

____ ____________________
Student Signature Date

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Physical Examination

Date: ______________________________
Must be within 12 months of the start of Clinical Experience

Student Name: ______________________________
Print Clearly

To the Medical Professional:

In order to ensure the safety of students and patients, a recent physical Examination is required for all students entering a healthcare program. Students work in all environments where the sick and injured may be cared for. They are required to sit, stand and walk for extended periods of time as well as lift, turn and care for patients in a clinical setting. Students are physically challenged through out this course. Your signature certifies that the following statements are true:

- This individual has been examined and found to be fit to participate without restriction in the strenuous activities demanded of a Healthcare Professional.
- This individual has been found to be free of any contagious disease, which may cause a threat to patient safety.
- This individual is physically and mentally competent to perform the duties required in a rigorous, performance based educational experience.

______________________________ ______________
Signature of Examining Medical Professional Date

____
Print Name of Examining Medical Professional (MD, PA or NP)

____
Address

______________________________ ______________ ________
City State Zip

____
Telephone Number

Request, Authorization, Consent
and
Release for Background Check

Please Type or Print

I, ____

Last Name First Name Middle Name (Include Jr., Sr., II, III Etc.)

Understand that in conjunction with my application for employment, American Academy of Healthcare, LLC, will use the services of an outside agency to research and verify the information I have provided on my application for patient contact including my personal background and character. This agency will provide a report to American Academy of Healthcare, LLC. American Academy of Healthcare, LLC uses a screening agency, as an agent to perform background verifications.

These agencies will utilize various sources of information it deems appropriate including but not limited to: credit reporting agencies, Workers Compensation records, Department of Motor Vehicle records, criminal conviction records, current and former employers, military records, education records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information including but not limited to the above to American Academy of Healthcare, LLC.

I request, authorize and consent to the procurement of an Investigative Consumer Report and understand that it may contain information about my background, mode of living, character, personal characteristics and general reputation. This authorization in original or copy form shall be valid for one year from the date indicated next to my signature. According to the Fair Credit Reporting Act, I will be notified by American Academy of Healthcare, LLC if enrollment is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to American Academy of Healthcare I further understand that when requesting a copy of the report, proper identification will be required and I should direct my request to:

BIB

LAW ENFORCEMENT AGENCIES AND OTHER ENTITIES FOR POSITIVE IDENTIFICATION PURPOSES REQUIRE THE FOLLOWING INFORMATION WHEN CHECKING PUBLIC RECORDS. IT IS CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. I HEREBY RELEASE AMERICAN ACADEMY OF HEALTHCARE AND ITS AGENTS, BACKGROUNDS ONLINE AND ALL PERSONS, AGENCIES, AND ENTITIES PROVIDING INFORMATION OR REPORTS ABOUT ME FROM ANY AND ALL LIABILITY ARISING OUT OF THE REQUEST FOR OR RELEASE OF ANY OF THE ABOVE MENTIONED INFORMATION OR REPORTS.

____________________________________ ____________________

Signed Date

____________________________________ Phlebotomy Student

Printed Name Position Applied For

____________ ____________ ____________ ________

Social Security Number Date of Birth Driver's License Number State

Other names you have used or are also known as:____________________________________

Residential Addresses for last 7 Years:

Current Address: ____

Street Apt. # City State Zip Code How long here?

Former Address: ____

Street Apt. # City State Zip Code How long here?

Former Address: ____

Street Apt. # City State Zip Code How long here?

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Competency Evaluation Skills Testing Procedures

To successfully pass the clinical and skills competency evaluation, the student must demonstrate unassisted, 100% mastery of all skills based on identified critical elements as outlined in the Phlebotomy curriculum.

The skills evaluation will be completed in the clinical setting as well as the classroom, but the student must complete a simulation practice test and show competency before clinical demonstration in a skilled facility.

The student has two other opportunities to prove 100% mastery of skills to be allowed to continue with the program, which is not more than three total attempts. If the student fails on the third attempt, they will be asked to withdraw from the program. **NO REFUND WILL BE MADE.**

It is the Phlebotomy instructors' responsibility to ensure that the skills the competency skills the student's demonstrate are signed off on an appropriate documentation as necessary are made.

The Phlebotomy instructor is responsible for the students training and evaluation through out the program.

______________________________ ______________________

Print Student Name Last 4-digits of S.S. #

______________________________ ______________________

Student Signature Date