MEDICAL ASSISTING CERTIFICATE PROGRAM APPLICATION PACKET

Application Instructions

Thank you for your interest in the Medical Assisting Certificate Program at the College of Professional Education at Kennesaw State University. Please read the following instructions carefully.

To participate in the externship, you must complete the application packet as soon as possible following registration, but no later than 30 days after the course start date. Failure to complete the packet will result in expulsion from the course. No exceptions. For students interested in using WIOA funding, please submit both the WIOA and Medical Assisting applications as soon as possible to allow up to 6 weeks for WIOA processing.

Print and complete this application in blue or black ink.

To be considered for this program, please complete and return ALL sections of the Application Packet:

1. **Student Information**
2. **Release, Waiver of Liability & Covenant Not To Sue**
3. **Human Subjects Document**
4. **Medical Assisting Program Expectations**
5. **Health History & Immunizations** *(Must be completed by Healthcare Provider. Attach a copy of your medical records and titer values report to support this document.)*

Students must also provide a clear copy of the following with their Application Packet:

6. Current personal Health Insurance card (front and back)
7. Current Driver's License
8. Social Security Card (signed)

HOW TO RETURN COMPLETED APPLICATION PACKETS

In Person:

KSU Center (South Entrance) the black, lock box to the right of the large flyer rack

3333 Busbee Drive, Kennesaw, Georgia 30144

Fax:

470-578-9083

A member of the Healthcare Team will email applicants directly about the acceptance status of their application packet within 7 – 10 business days of application submission.

Estimated Expenses

Students will be responsible for the following items prior to clinical externship. More information and directions on how and when to purchase will be provided after you are enrolled in the program. These are minimum, estimated costs to help you plan accordingly.

- Criminal Background Check, Drug Screen $80**
- Second TB Skin Test, Seasonal Flu Shot $50**
- Uniforms $150
- Stethoscope $60
- Watch with secondhand $20
- White Shoes $50
- NHA Certification Exam $155

** Students in the Medical Assisting Certificate Program may be required to complete an additional criminal background check, drug screen, TB Skin Test, or seasonal flu shot prior to participation in the onsite clinical externship portion of the program. Based on the results of the criminal background check and drug screen, hospitals or clinical facilities where you will participate in onsite training may deny you access to their facility – resulting in your inability to successfully complete the Medical Assisting Certificate Program. If you are unable to complete the clinical portion of your training, you will be unable to progress in the program.

For recommended TB Skin Test locations from Cobb & Douglas Public Health, please visit:

https://www.cobbanddouglaspublichealth.com/about-us/locations-hours/

Textbook required for the program are available at the KSU Center Bookstore. For more information, visit: con-edbooks.kennesaw.edu for more information.

Student Information

Personal Information

NAME _____
Last *First* *Middle* *Maiden*

ADDRESS _____
Street *City* *State* *Zip*

PHONE ( ) _____ ( ) _____ ( ) _____
Daytime *Cell* *Evening*

EMAIL _____
All correspondence regarding the program will be sent to this email address

PERSONAL: _____
Date of Birth

Short Answer

Why do you want to become a Medical Assistant?

I affirm, agree, and/or understand that all statements on this form are true and accurate; any misrepresentation or omission of material facts may result in removal from the program.

_____ _____
Signature of Applicant *Date*

FOR OFFICE USE ONLY:

Date Received:

KENNESAW STATE UNIVERSITY
COLLEGE OF PROFESSIONAL EDUCATION

RELEASE, WAIVER OF LIABILITY & COVENANT NOT TO SUE

(READ CAREFULLY BEFORE SIGNING AND BRING TO FIRST CLASS SESSION)

The undersigned hereby acknowledges that participation in off-site excursions, classes and recreational activities involves inherent risks of physical injury and assumes all such risks. The undersigned hereby agrees that for the consideration of Kennesaw State University allowing the undersigned to participate in off-site excursions, classes or recreational activities and, in connection therewith, making available to the undersigned for facilities, grounds, or personnel of the institution, the undersigned participant does hereby waive liability, release and forever discharge the institution and the Board of Regents of the University System of Georgia, its members individually, and its officers, agents and employees of and from any claims, demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, including death, resulting from my voluntary participation in or in any way connected with such off-site excursions, classes or recreational activities.

I further covenant and agree that for the consideration stated above I will not sue the institution, the Board of Regents of the University System of Georgia, its members individually, its officers, agents, or employees for any claim for damages arising or growing out of my voluntary participation in off-site excursions, classes or recreational activities.

I understand that the acceptance of this release, waiver of liability and covenant not to sue the institution of the Board of Regents of the University System of Georgia or any agent or employees thereof, shall not constitute a waiver, in whole or in part of sovereign or official immunity by said Boards, its member, officers, agents, and employees.

Further, I understand that this release, waiver of liability, and covenant not to sue shall be effective during the time period indication below while I am participating in activities sponsored by Kennesaw State University.

COURSE NAME_____ DATES_____

_____ I authorize Continuing Education at KSU to share this information with the instructor(s). Please check.

Signature:_____ Date:_____
Participant or Legal Guardian if participant under the age of 18.

Print Name:_____

Emergency Contact Name & Telephone Number:

_____

Please list any special health problems/allergies/medications:

_____

Human Subjects Document

Assumption of Risk & Consent to Procedures

General Information

During this course you will be participating in laboratory activities in which learning by students requires the use of human subjects as part of the training. As a part of these learning activities you will be asked to perform specific skills as well as be the subject of specific skills practiced by students. These learning activities will be conducted under the supervision of the course instructor.

Benefits

The activities have been selected because they are skills essential to the learning process and the faculty believes that realistic practice is essential for optimum learning.

Bloodborne Pathogen Exposure

It is important that you be aware that blood and other body fluids have been implicated in the transmission of certain pathogens, particularly Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV), the virus responsible for Acquired Immune Deficiency Syndrome (AIDS). In order to minimize risk of exposure to bloodborne pathogens, the student must agree to follow Standard Precautions guidelines as well as comply with regulations outlined in the OSHA Bloodborne Pathogen Standard.

Risks/Discomforts

Participation may create some anxiety or embarrassment for you. Some procedures may create minor physical or psychological discomfort. Specific risks are listed below.

Your Rights

You have the right to withhold consent and to withdraw consent after it has been given. You may ask questions and expect explanation of any point that is unclear.

LEARNING ACTIVITY	SPECIFIC BENEFIT	RISKS/DISCOMFORTS
Venipuncture using both evacuated tube system (ETS) and syringe system.	Student gains experience needed prior to performing procedures on actual patients.	Possibility of hematoma or bruising; slight, temporary pain with procedure; slight risk of temporary nerve inflammation; blood or body fluid exposure.
Skin puncture of the finger tip.	Student gains experience needed prior to performing procedures on actual patients.	Slight, temporary pain upon puncture; minimal possibility of infection (provided area is kept clean); blood or body fluid exposure.
12-lead ECG lead(s) placement and removal.	Student gains experience needed prior to performing procedures on actual patients.	Slight, temporary pain upon removal of lead(s); possibility of allergy to glue on lead(s); temporary discomfort during state of disrobe.

I have read the above Human Subjects Document. I acknowledge my understanding of the risks and benefits described. My questions have been answered. I agree to participate as a subject in the learning activities listed above.

Signature of Student
(Parent or Guardian if student is under 18 years of age)

Date

Printed Name: _____

Medical Assisting Program Expectations

This form must be signed and returned as a part of the Medical Assisting program application

Requirements & Regulations

Program Completion

Students must successfully complete each module (class) of the Medical Assisting program with a grade of 75% or higher and meet the 80% attendance policy in order to advance to subsequent modules. Students must successfully complete every module, including the clinical externship, in order to successfully complete the program and sit for the National Healthcareer Association Exam.

Classroom Clinical Skills Labs

Students must dress appropriately for classroom clinical skills labs by wearing close-toed shoes and having all hair tied back securely. Scrubs are recommended but not required for classroom clinical skills labs. Students must behave in a professional manner, including proper handling of equipment/supplies and following proper waste disposal procedures.

Clinical Externship Regulations

KSU's externship partners assign the clinical externships to students based on availability. KSU does not guarantee particular locations, working hours, or areas of practice to any student. Students may not have a conflict of interest with their assigned site (current or former employer). The externship is not for pay. Students must be available for the clinical externship during physician office hours, Monday—Friday from 8am-5pm.

Documentation Details

Health Insurance

Medical Assisting students are required to have active health insurance coverage from the time of application through the last day of clinical externship (two calendar years).

- Students must provide a clear copy of the front and back of the card
- Student's legal name must be clearly displayed on the card*
- The current calendar year must be clearly displayed on the card*

*If the card does not specify a student's name or the current calendar year (as some companies ask members keep the card from one year to the next), backup documentation in the form of an email confirmation from the insurance provider must be provided.

Immunizations

All immunizations are due in full at the time of the program application. See Health History & Immunizations form for a full list of immunization records due at this time. Be sure to attach a copy of your medical records and titer values report. As further clarification on immunization expiration dates/due dates:

- COVID vaccination with copy of CDC card
- TB Test dates – no older than 6 months prior to the program start date. A second TB Test will occur prior to the clinical externship.
- Tdap dates – no older than 10 years from program end date
- Hepatitis B series – 2-dose series, 3-dose series, or positive titer accepted
- Flu Shot – completed prior to the clinical externship (not necessary at time of application)

I have read and I understand the above Medical Assisting Program Expectations.

_____ _____

Signature of Applicant *Printed Name*

Date: _____

Health History & Immunizations

This form must be completed and signed by your Healthcare Provider

Personal Information

NAME _____ **DATE OF BIRTH** _____

Immunization History

***** PLEASE ATTACH A COPY OF YOUR MEDICAL RECORDS AND TITER VALUES REPORT TO SUPPORT THIS DOCUMENT *****

COVID VACCINATION

**** Must have 2 of the following ****

1st Dose Date _____ 2nd Dose Date _____ 3rd Dose Date _____

A copy of the CDC COVID vaccination card must be provided with application packet.

TB TEST

**** Skin Test or Chest X-Ray must be negative. No older than 6 months from program **start** date ****

Date _____ Measurement of induration in millimeters _____

Chest X-Ray Date _____

Current treatment for latent TB, please indicate medication dose, frequency and duration _____

Provider Signature _____ **Date** _____

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap)

**** No older than 10 years from program **end** date****

Date _____

TD Date _____ ** If less than 2 years*

MEASLES, MUMPS, RUBELLA (MMR)

**** Must have 2 immunizations OR Positive Titer ****

Date of Immunization #1 _____ #2 _____

Positive Measles Titer Date _____

Positive Mumps Titer Date _____

Positive Rubella Titer Date _____

HEPATITIS B

**** Must have immunizations via 3-dose series or 2-dose series OR Positive Titer ****

2-dose Date of Imm. #1 _____ #2 _____

3-dose Date of Imm. #1 _____ #2 _____ #3 _____

Positive Titer Date _____

VARICELLA

**** Must have 1 of the following ****

Date of Disease _____

Date of Immunization #1 _____ #2 _____

Positive Titer Date _____

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

The student above is capable of performing duties as a Medical Assistant.

Healthcare Provider Signature _____ **Date** _____

Healthcare Provider Name (Print) _____

Address _____

Phone Number _____

Application Packet Checklist

Please return completed Application Packet to KSU. Incomplete packets will not be accepted.

1. Did you fill out the **Student Information?**
2. Did you read and fill out the bottom section of the **Release, Waiver of Liability & Covenant Not To Sue?**
3. Did you read and fill out the bottom section of the **Human Subjects Document?**
4. Did you read and sign the **Medical Assisting Program Expectations?**
5. Did your Healthcare Provider fill out all sections of the **Health History & Immunizations**? Did you attach a copy of your medical records showing your immunizations? If you have Titers, did you attach the values report?
6. Did you make a front/back copy of your **Current, personal Health Insurance card**? If your card does not list your name or the current calendar year, did you attach a letter from your provider confirming your coverage for this year?
7. Did you make a copy of your current **Driver's License?**
8. Did you make a copy of your signed **Social Security Card?**

END OF APPLICATION PACKET