Conviction/Criminal History Disclosure Form

This form must be completed to be considered for Allied Health Programs admission and continuation

Renton Technical College reviews conviction/criminal history records when considering individuals for admission and continuation in Allied Health programs. These reviews are carried out because they relate to the essential qualifications of potential and continuing students under the Allied Health program curriculum standards, as well as to the safety and security of patients and the public. The Washington State Child and Adult Abuse Information Law RCW 43.43.830-842, requires that anyone with unsupervised access to certain vulnerable populations be screened for specific information about any convictions for crimes against persons and crimes relating to financial exploitations, and for findings in related actions and proceedings. This conviction information must be disclosed before any student can be considered to train in any position which may involve unsupervised access to children, developmentally disabled persons or vulnerable adults as defined by the law. Certain criminal convictions and court administrative determinations may preclude completion of the clinical portion of the curriculum since clinical training sites are precluded by law from allowing persons with certain convictions histories to have unsupervised access to these vulnerable populations. Contracts with clinical training sites require that students enrolled in Allied Health programs have been screened before being assigned to their sites.

Conviction information, including information regarding certain court and administrative determinations, must be disclosed and verified before an applicant or student can be considered for enrollment or continuation in the Allied Health programs. A conviction/criminal history record does not necessarily disqualify an individual from admission or continuation, however admission and/or continued enrollment is subject to a satisfactory background check review. The conviction/criminal history records must be verified through a private national background check agency specified by the College.

Individuals who do not sign this Conviction/Criminal History Disclosure Form will not be considered for admission or continuation. Questions about the use of conviction/criminal history information may be referred to the Dean of Allied Health Programs.

First Name:		Last Name:		SID:	

I. CRIMES AGAINST PERSONS AND CRIME RELATING TO FINANCIAL EXPLOITATION

Have you ever been convicted of any of the following crimes? If **YES**, please check all that apply and provide detailed information in section VI. ☐ Yes ☐ No

	Arson (1st Degree)		Custodial Interference (1st, 2nd Degree)		Prostitution
	Assault (Custodial)		Extortion (1st, 2nd, 3rd Degree)		Promoting Prostitution (1st Degree)
	Assault (Simple or 4th Degree)		Forgery		Rape (1st, 2nd 3rd Degree)
	Assault (1st, 2nd, 3rd Degree)		Incest		Rape of a Child (1st, 2nd, 3rd Degree)
	Assault of a child (1st, 2nd, 3rd Degree)		Indecent Exposure (Felony)		Robbery (1st, 2nd Degree)
	Burglary (1st degree)		Indecent Liberties		Selling/Distributing Erotic Material to a Minor
	Child Abandonment		Kidnapping (1st, 2nd Degree)		Sexual Exploitation of a Minor
	Child Abuse or Neglect (RCW 26.44.020)		Malicious Harassment		Sexual Misconduct with a Minor
	Child Buying or Selling		Manslaughter (1st, 2nd Degree)		Theft (1st, 2nd, 3rd Degree)
	Child Molestation (1st, 2nd, 3rd Degree)		Murder (Aggravated)		Unlawful Imprisonment
	Communication with a Minor		Murder (1st, 2nd Degree)		Vehicular Homicide
	Criminal Abandonment		Patronizing a Juvenile Prostitute		Violation of Child Abuse Restraining Order
	Criminal Mistreatment (1st, 2nd Degree)		Promoting Pornography		Or Any of These Crime That May Have Been Renamed

II. RELATED PROCEEDINGS

Have you ever been found in a dependency action, domestic relations proceeding, disciplinary board hearing, or protection proceeding to have: sexually assaulted or exploited, sexually or physically abused a minor or developmentally disabled person OR to have financially exploited or abused a vulnerable adult? If YES, please provide detailed information in Section VI.

☐ Yes ☐ No
If YES, please provide detailed information in Section VI.

III. DRUG-RELATED CRIMES

Have you ever been convicted of a crime related to the manufacture of, delivery, or possession with intent to manufacture or deliver a controlled substance?

☐ Yes ☐ No
If YES, please provide detailed information in

	Section VI.
IV. MEDICARE FRAUD-RELATED CRIMES	
Have you been debarred, excluded or otherwise ineligible for participation in federal health care programs?	☐ Yes ☐ No If YES, please provide detailed information in Section VI.
V. HEALTH CARE LICENSURE	
Have you ever had your license as a health care practitioner revoked?	☐ Yes ☐ No If YES, please provide detailed information in Section VI.
VI. FOR ALL ITEMS CHECKED IN SECTIONS I – V, PLEASE SPECIFY: 1) The specific details including the court or agency involved 2) Conviction or action date(s) 3) Sentence(s) or penalty(ies) imposed 4) Prison release date(s) 5) Current standing (e.g. parole, work release, suspended license, etc.) Please use other side of page if necessary	
VII. GENERAL CONVICTION INFORMATION	
Aside from those crimes listed above, within the past 10 years, have you ever been convicted of or released from prison for any crimes, excluding parking tickets/traffic citations? If YES, please indicate all conviction dates, prison release date(s) and the nature of the offense(s). Please use other side of page if necessary.	☐ Yes ☐ No
Under penalty of perjury, I certify that the above information is true, correct and complete. I understand that I am obligated to notify the Allied Health program within 30 days, in writing , of if I am convicted of any crime or if any of the specified court or administrative determinations are made against me during the application period and/or while enrolled as a student. I understand that any misrepresentation or omission in the above-stated information may lead to denial of admission or dismissal. I understand and agree that the Renton Technical College Allied Health Programs may verify this information through a private national background records verification agency. I also understand and agree that admission and continuation is conditional on the Program's receipt of a satisfactory background check report from the agency. **Authorization for Repeat Background Checks and Dissemination of Results:** **I agree to initiate, pay for and provide the Allied Health program with repeat background check every year from the date of my admission to the program. I authorize dissemination of my self-disclosure information, background check results, and conviction records to clinical training sites as deemed necessary by the Allied Health program during the completion of my academic program. I understand that the Allied Health program will provide the records listed above only with the condition that the receiving party or parties will be notified by the Allied Health program that they may not disclose the information to other parties, in a personally-**	

identifiable form, without my further consent, unless the other parties are otherwise eligible under federal or state law to receive the records. I further understand that any statements that I have placed in my records commenting on consented information contained in the records listed above will be released along with the records to which they relate.

Signature	Date		

Process for Background Check Review:

1. All applicants/students submit a signed Conviction/Criminal History Disclosure Form

2. Every applicant must verify conviction/criminal history through the private national background check agency specified by the Allied Health Program, by the stated deadline. Failure to comply by the deadline may disqualify the applicant from admission.

3. All continuing students must complete a repeat check every year

4. If the check result is negative, the applicant may be admitted to and the continuing student may continue in the program

5. If the check result is positive, the applicant/student will be asked to explain any discrepancies. This information will be reviewed by a program dean. If the review indicates that the information and explanation are satisfactory, the applicant may be admitted to and the continuing student may continue in the program. If the review indicates that information and explanation are not satisfactory, the offer of admission may be withdrawn and the continuing student may be suspended or dismissed from the program

6. A program dean will meet with the applicant/student and inform the applicant/student of the decision regarding the background check review verbally and in writing.

RENTON TECHNICAL COLLEGE
HEALTH RECORD
FOR PARTICIPATION IN
ALLIED HEALTH
DEPARTMENT
PROGRAMS

DATE: _____

PROGRAM: _____

NAME:_____

STUDENT NUMBER:
_____

DATE OF BIRTH: ___/___/_____

ADDRESS: _____ PHONE: _____ AGE: ____

This evaluation is only to determine readiness for participation in an allied health program. It should not be used as a substitute for regular health maintenance examinations. The Health History and physical examination record sections must both be completed, prior to entry into the allied health program. Please have your completed form for your student record.

HEALTH HISTORY:

To be completed by student

1. Have you ever had an illness that: YES NO
   a. Required you to stay in the hospital? ___ ___
   b. Lasted longer than a week? ___ ___
   c. Is related to allergies? (i.e. hay fever, hives, asthma, insect stings) ___ ___
   d. Required an operation? ___ ___
   e. Is chronic? (asthma, diabetes, anemia, epilepsy) ___ ___

2. Have you ever had an injury that:
   Caused you to miss more than three consecutive days of participation in usual activities this past year? ___ ___
   If yes, please indicate:
   Site of injury_____
   Type of injury_____
   a. Required you to go to an emergency room or to see a doctor? ___ ___
   b. Required to stay in the hospital? ___ ___
   c. Required x-rays? ___ ___
   d. Required an operation? ___ ___

3. Do you take any medication or pills? ___ ___
   List all medications you are presently taking and what condition the medicine is for?
   a. _____
   b. _____
   c. _____

4. Have any members of your family under the age of 50 had a heart attack, heart problems, or died unexpectedly? ___ ___

5. Have you ever:
   a. Been dizzy or passed out during or after exercise? ___ ___
   b. Been unconscious or had a concussion? ___ ___

6. Are you unable to run ½ mile (2 times around the track) without stopping? ___ ___

YES NO

7. Do you have any problems standing for long periods? Or walking? ___ ___
   Ability to lift 50 lbs or more ___ ___

8. Do you wear glasses or contacts? ___ ___

9. Have you ever had a heart murmur, high blood pressure, or a heart abnormality? ___ ___

10. Do you have any allergies to any medicine? ___ ___
    If yes, what? _____

11. Do you have any skin conditions? ___ ___
    Particularly arms and/or hands ___ ___

12. Are you missing a kidney? ___ ___

13. Any psychological illness? ___ ___
    Are you currently being treated
    If so, what medication? _____

14. **For Women:**
    a. At what age did you experience your first menstrual period?_____
    b. In the last year, what is the longest time you have gone between periods?_____

15. Are you worried about any problem or condition at this time? ___ ___
    If yes, please explain:
    _____
    _____

16. Year of Last Complete Physical? _____

17. Is there a family history of: Diabetes, Polycentric Kidneys, Congenital Heart Disease, Hypertension, Breast Cancer, GI Cancer, etc.?
    Who? _____
    _____
    _____
    _____

I hereby state that, to the best of my knowledge, my answers to the physical exam history are correct.
Date: _____ Student Signature: _____

Renton Technical College
Allied Health Department

PRINT YOUR NAME: _____

STUDENTS: DO NOT WRITE BELOW THIS LINE
FOR PHYSICIAN / NURSE PRACTIONER or PA ONLY

Height _____ Weight _____ Pulse_____ Blood Pressure _____

Percent Body Fat (optional) _____

	Normal	**Abnormal Findings**
Eyes		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Chest and lungs		
Abdomen		
Skin		
Genitalia – Hernia (male)		
Musculoskeletal: ROM, Strength		
A. Neck		
B. Spine		
C. Shoulders		
D. Arms/Hands		
E. Hips		
F. Thighs		
G. Knees		
H. Ankles		
I. Feet		
Neuromuscular		

Participation recommendations: Full Participation _____

1. No Participation in
   _____
2. Limited participation in
   _____

Health Care Provider Signature _____ Date _____

Telephone number _____ Address _____

TUBERCULOSIS (TB) SCREENING FORM

SELF-ASSESSMENT (TO BE COMPLETED BY PATIENT OR PARENT/GUARDIAN)

Name: Last:_____First:_____Middle:_____Date of Birth:___/___/___

Address:_____
Street Apt. # City State Zip Code

Phone: ( ) _____ ( )_____ ( )_____
Home Cellular Emergency Number

1. Have you ever had a TB skin test? Yes_____ No_____ Don't Know_____
   - If yes, when was it? ____/____/____ Result? Positive____ Negative___Don't Know____
   - If positive, do you have the documentation? Yes_____No_____
2. Did you have a chest x-ray after your skin test? Yes_____No_____
   - If yes, when was it? ____/____/____
   - Where was it? (e.g. name of hospital, doctor, clinic)_____
3. Have you ever been told that you have TB? If so, when was it? ____/____/____
4. Have you ever been treated for TB infection or TB disease? Yes_____No_____
   - Which medicines did you take?_____
   - How long were you on the treatment?_____
     _____

Please indicate your answers in one of the columns to the right	**Yes**	**No**	**Don't Know**
5. Have you ever been told, or suspected, that you were exposed to someone with TB? • If yes, when:____/____/____ Name/Relationship:_____			
6. Have you ever had cancer of the head, neck, or lung: leukemia; or lymphoma?			
7. Have you ever had an organ or tissue transplant?			
8. Are you taking steroids (like prednisone), chemotherapy or drugs that affect your immune system?			
9. Do you have diabetes or high blood sugar?			
10. Do you have any of the following symptoms:			
• Cough longer than 2 weeks? Date when you first noticed____/____/____			
• Fevers, chills, night sweats longer than 2 weeks? Date when you first noticed____/____/____			
• Weight loss that was not planned? Date when you first noticed ____/____/____			
11. Do you have renal failure, or are you on kidney dialysis?			
12. Do you think you are at risk of having HIV infection?			
13. Have you ever injected street drugs?			
14. Were you born outside of the United States? If yes, what country? _____			
15. (If patient under 18) Has anyone who lives with you moved to the U.S. within the last 5 years? If so, which country? _____			
16. Have you had any visitors from outside the U.S.? When?_____ Where were they from?_____			
17. Have you traveled to any other countries recently? Where?_____ How long did you stay?_____			
18. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison?			

If you answered "Yes" to any of the questions from 5 to 18, you may be at increased risk of having TB infection or developing active TB. If you answered "No" to all, you are not considered at higher risk for TB.

_____
Patient or Parent/Guardian Signature

RTC RENTON TECHNICAL COLLEGE

ASSESSMENT OUTCOME AND TB TEST ADMINISTRATION (TO BE COMPLETED BY CLINICIAN)

Prior Documentation (or convincing history) of TB or LTBI:

_____ No TB test needed. *Patient may still need evaluation for treatment for LTBI or active TB*

TB Risk Category (check only one):

_____ **Medical risk factor (includes contacts to active TB cases)** (questions 5-12)

_____ **Population risk factor** (questions 13-18)

_____ **Administrative** (TB test required only for work, school, etc.)

Screening Test: _____TST (PPD) Mantoux (0.1 ml of tuberculin) _____**Blood Test** (QuantiFERON TB Gold)

Test Date: _____/_____/_____

Tuberculin lot number: _____ Expiration date: _____/_____/_____

Date interpreted: _____/_____/_____ Result: _____mm _____Positive or _____Negative

Blood Test IFN concentration: _____ IU/ml

Result: _____Positive _____Negative _____Indeterminate

Two Step Testing for Health Care Workers (applicable only if initial TST was negative):

2nd TST Mantoux Test Date: _____/_____/_____

Tuberculin lot number: _____ Expiration date: _____/_____/_____

Date interpreted: _____/_____/_____ Result: _____mm _____Positive or _____Negative

STEP ONE AND TWO MUST BE READ 48-72 HOURS FOLLOWING ADMINISTRATION

PHYSICAL EXAM: Date: _____/_____/_____ No signs of TB _____ **or** Abnormal, Suggested TB _____

CHEST X-RAY: Date: _____/_____/_____ Reading:_____

OUTCOME (check only one):

_____LTBI treatment prescribed
_____No treatment needed (not infected)
_____No treatment indicated (low TB risk)
_____Treatment deferred due to _____
_____Patient being evaluated as a TB suspect
_____Patient refused treatment
_____Treatment not advised due to high risk of hepatitis
_____Previously treated for TB or LTBI
_____Other_____

Follow-up/Comments (include treatment regimen):

_____
Provider Signature

_____
Provider Name (please print)

_____
Date

PERMISSION TO RELEASE INFORMATION

I hereby give my permission to Renton Technical College to release information to any sponsoring governmental, private agency or prospective employers regarding my attendance, grades, and/or general progress at Renton Technical College.

I also authorize Renton Technical College to collect and release all necessary background check information (including, but not limited to: National criminal background check, Washington State Patrol background check, OIG and GSA Excluded Providers database search), and immunization records to any affiliated clinical education site* requesting such information in order to finalize my externship placement with those facilities.

Date:_____

_____ _____

Student Name (please print) **Student Signature**

***An affiliated clinical education site is any business or agency with which the college has signed a contract to provide clinical education experiences for students.**

RTC RENTON TECHNICAL COLLEGE

STUDENT HANDBOOK ACKNOWLEDGEMENT

I have read the Renton Technical College Student Handbook (accessible on-line at www.rtc.edu, Student Services, Student Handbook).

I understand that I am obliged to abide by the policies and guidelines outlined in the handbook while I am a student at Renton Technical College.

Signature:_____

Printed Name:_____

Date:_____