Cedar Valley College
Patient Care Technician Certification

This 322-hour comprehensive course one of our Allied Health professional programs which provide hands on training with direct patient care within their regulated scope of practice. They perform basic nursing assistant tasks (as delegated by the nursing or medical staff) which may include obtaining patient vital signs and other data, communicating with the healthcare team and patients, assisting with activities of daily living (ADLs), complying with confidentiality requirements, performing ECGs and Phlebotomy tasks. Completers of this program are eligible to sit for the national examination through the NCCT, National Center for Competency Testing.

Note: For students enrolled in the Patient Care Technician program, additional certificates are available. EKG Technician Certification, Phlebotomy Technician with completion of a clinical rotation, and Certified Nursing

Class Outline	Hours
Medical Terminology (HITT 2031)	48
Anatomy and Physiology (MDCA 1009)	48
Phlebotomy (PLAB 1023)	80
ECG Technician (ECRD 1011)	50
Nurse Aide (NURA 1001)	60
CPR * (EMSP 1019) *prereq	8
PCT Clinical (NUPC 1091)	36
PCT Exam Review (NURA 2000) *optional	24
Total	322

Statement of Student Responsibility

Review and initial each section as verification that you have read and understand this information:

_____I acknowledge that this information packet contains policies, regulations, and procedures in existence at the time this publication went to press. I also acknowledge that the District Colleges including Cedar Valley College reserve the right to make changes at any time to reflect current Board policies, administrative regulations and procedures, and applicable State and Federal regulations. Furthermore, I understand that this packet is for informational purposes only and does not constitute a contract, expressed or implied, between any applicant, student or faculty member and the Dallas County Community College District.

_____I accept full responsibility for submitting a complete application packet and understand incomplete materials including missing or incomplete forms; CPR certification will disqualify my application. I also accept the responsibility of informing Continuing Education Office of any change in my status, address, telephone number, or other information that would affect my application status.

____I understand that if accepted to Continuing/Workforce Education health program, all forms, immunization records, etc. submitted with my packet becomes the property of Continuing/Workforce Education and will not be returned nor photocopied for me. I also authorize the release of these records to any of my clinical sites which may require them.

_____I acknowledge that I must comply with class attendance requirements, if I am absent from class for more than 10% of class than I can be asked for a doctor's note or restart the class at a later time.

____I acknowledge that EKG Program at Cedar Valley College does not offer a clinical rotation, however if I choose to pursue any other Allied Health Program then a clinical rotation is required. In this event I may be assigned to clinical rotations at area healthcare facilities which may require additional proof of immunity or additional inoculations/immunizations. I also acknowledge that I am required to have health care coverage through the duration of my courses.

_____I acknowledge that a criminal background check and mandatory drug screening are required before I am allowed to attend clinical. I understand that the results of these screenings become the property of Continuing/Workforce Education and will not be released to me or any other third party. I also understand that the outcome of these screenings may results in my dismissal from Cedar Valley, Continuing/Workforce Education, and Allied Health Programs.

Applicant's Signature

Drug Screens

Cedar Valley College and/or a clinical agency reserve the right to remove a student from the classroom or clinical facility for suspicion of drug or alcohol use and to submit to a drug and alcohol screen at the student's expense. Additionally, the college and/or clinical agency reserve the right to request that a student submit to a drug and alcohol screen at random at the student's expense.

Students with a positive drug screen without an authorized provider prescription or a positive alcohol screen will be removed from Cedar Valley College Continuing Education Health Programs. Failure to comply with a drug screen request from Cedar Valley or one of its clinical agencies will result in the student's immediate expulsion from the Cedar Valley College program. Furthermore, regardless of testing or testing results, clinical agencies reserve the right to remove students from their facilities.

The drug screen follows National Institute on Drug Abuse guidelines and screens for 10 substances, as designated in the Substance Abuse Panel 10, "SAP 10." These substances are: amphetamines, barbiturates, benzodiazepines, cocaine metabolites, alcohol, marijuana metabolites, methadone, opiates, phencyclidine and propoxyphene. SAP 10 test results that fall outside of any of the acceptable ranges are considered positive test results and are automatically sent for a separate confirmatory test by a gas chromatography mass spectrometry method. If these results are positive, the test results are sent to a medical review officer who will review the results at an additional cost to the student. The medical review officer will then contact the student to determine if there is a valid prescription for the drug in question. If a valid prescription exists and is verified, the test result will be deemed negative and acceptable.

An individual with a positive drug screen will not be allowed to enroll in any health-related continuing education courses for a minimum of 12 months according to the Community Standard. Prior to enrolling or returning to the clinical agency/rotation, a student must provide proof of a negative drug screen as verified by the college/school. Failure to comply with this policy will result in disciplinary action and dismissal from the Cedar Valley College program.

Criminal Background Check

The criminal background check reviews a person's criminal history at least seven years prior to the date of program application. The check will include all cities and counties of the person's residency during that time period.

The following histories will disqualify an individual from consideration for a clinical rotation:

- felony convictions;
- misdemeanor convictions or felony deferred adjudications involving crimes against persons, e.g. physical or sexual abuse;
- misdemeanor convictions related to moral turpitude, e.g. prostitution, public lewdness/exposure, etc.;
- felony deferred adjudications for the sale, possession, distribution or transfer of narcotics or controlled substances; or status as a registered sex offender.

Registration Process and Checklist

Step 1: Complete the Registration Packet with supporting documentation and return to the Program Coordinator with an appointment in M225I between M-F from 8am to 6pm.
Step 2: After obtaining approval from the Allied Health Coordinator, register with Advisor in "L" Building

- Proof of high school diploma or equivalent
- A copy of current Basic Cardiac Life Support, BCLS, for Health Care Providers completion card
- A copy of valid U.S. or Texas State Government Issued Photo I.D. (e.g. driver's license)
- U.S. or Texas State Government Issued Photo I.D. (e.g. driver's license, passport)
- Dallas County Community College District, Continuing /Workforce Education Registration Form
- Application/Student Responsibility form
- Immunization form completed by a healthcare provider or AH Coordinator with documentation of Immunization record.
- Liability Insurance purchased and proof of Health Insurance at the time of Clinical Externship
- Cedar Valley ID Badge

For Allied Health Use Only:
Documentation Complete

_____
Signature, Date

Applicants to Workforce Development and Continuing Education health courses are responsible for retaining a photocopy of all documentation submitted for their personal records. Once this documentation has been submitted to Workforce Development and Continuing Education the documentation becomes the sole property of Continuing Education and will not be returned nor photocopied for the applicant, their instructors or any other party.

Continuing Education Health Careers

DCCCD STUDENT ID NO._____/_____/_____ DATE _____

NAME_____BIRTHDATE _____
Last First Middle I. Month/Day/Year

ADDRESS _____
Street City and State ZIP

TELEPHONE (____)_____ (____)_____
Home Business/Mobile

EMAIL_____

All forms in this packet must be completed and approved prior to registration.
Please bring the following documentation to the Cedar Valley College Continuing Education office. The Allied Health office is located in Building A, room 105, Monday – Thursday 8am to 6pm and Fridays from 8am to 5pm

Cedar Valley College Continuing Education/
Immunization Record

Last Name_____ First Name_____ Middle Initial_____

Date of Birth_____ Sex: ☐ M ☐ F Student ID Number _____

MEASLES (Rubeola)	HEPATITIS B / TWINRIX (HEP A/B)
Select option 1 or 2 and provide requested documentation. 1. Dates of immunization: Two (2) are required. A. First immunization with live attenuated virus (Given after 1957 and given on or after student's first birthday). B. Second dose separated by 28 days or more Date of immunization: ___/___/___ ( )* ___/___/___ ( )* OR 2. Date of blood titer ___/___/___ ( )* AND Quantitative result #: _____	1. Date of immunization ___/___/___ ( )* 2. Date of immunization ___/___/___ ( )* 3. Date of immunization ___/___/___ ( )* OR 3. Date of blood titer ___/___/___ ( )* AND Quantitative result #: _____
MUMPS	**TB**
Select option 1 or 2 and provide requested documentation. 1. Dates of immunization: Two (2) are required. A. First immunization with live attenuated virus (Given after 1957 and given on or after student's first birthday). Date of immunization: ___/___/___ ( )* ___/___/___ ( )* OR 2. Date of blood titer ___/___/___ ( )* AND Quantitative result #: _____	PPD Date:)* ___/___/___ ( )* Result: ☐ Negative ☐ Positive _____ mm. ( )* OR Chest X Ray: ___/___/___ ( )* Result: ☐ Negative ☐ Positive ( )* MUST BE WITHIN THE LAST YEAR AND YEARLY THERE AFTER
RUBELLA (German Measles)	**VARICELLA**
Select option 1 or 2 and provide requested documentation. 1. Dates of immunization: Two (2) are required. A. First immunization with live attenuated virus (Given after 1957 and given on or after student's first birthday). Date of immunization: ___/___/___ ( )* ___/___/___ ( )* OR 2. Date of blood titer ___/___/___ ( )* AND Quantitative result #: _____	1. 2 Doses (30 days apart or more ___/___/___ ( )* ___/___/___ ( )* Quantitative result #: _____ **FLU VACCINATION** Seasonal Flu Shot: ___/___/___ ( )* **Tdap/tetanus, diphtheria and acellular pertussis** Within 10 years for ALL students: Date of Immunization: ___/___/___ ( )*
MMR	**PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT SIGNATURE & DATE**
1. Date of Immunization: ___/___/___ ( )* 2. Date of Immunization: ___/___/___ ( )*	Signature _____ Date