Health Careers Certification – Sayre Campus

Instructor: Kim McClure, *BSN, RN*
Instructor: Kathy King - *BSN, RN*
Phone: 580-928-2097; **Email**: kmcclure@westtech.edu

The following items are due to Western Technology Center (WTC) **by January 29th before 4pm.** **Your enrollment in the Health Careers Program cannot be considered until all items are received and you and a parent/guardian have attended a Mandatory Parent Meeting.**

_____ **WTC Application Form** (QR code opens Dec. 2 at 8 am)

_____ **Parental and Student Consent Form**

_____ **Documentation of immunizations**. A copy of the entire immunization recorded is needed. **A TB test will be required after winter break for you to attend clinical but NOT for this application. It will expire prior to clinical.** This can be obtained free of charge at the local county health department. Hepatitis B series must be completed or at least started before application unless a declination form is included. This should already be completed for high school students. TB test will be required before Christmas Break if accepted to the program. Please note that students will be required to have the flu vaccine in season.

_____ **Letters of Reference**. Submit 3 letters of reference. These should be from current instructors, counselors, principals or from other people of responsibility who can give a reference of your desire or ability in the health care field. NO relatives.

_____ **Essay**. Submit a **500 word** essay. This essay is to include the following information: why you have chosen to pursue a health-related career; your career goals, and a recent medical or science or technology advance in health care that is of interest to you. Essays must be TYPED and on 8.5 x 11 inch paper with your name at the top right corner of each page.

_____ **Documentation of volunteer assistance**. Submit the enclosed form as documentation of at least 4 hours of volunteer assistance in a healthcare facility (nursing home, retirement center, assisted living center, hospital, home health agency, hospice, clinic, medical office, rehabilitation center, etc).

_____ **Background Check**.** Background checks are only required for students 18 years or older and can be found at http://www.ok.gov/osbi/Criminal_History/.

Important Information:

- Type of Search Requested should include: Name Based, Sex Offender, and Mary Rippy Violent Offender. Total=$19
- You do not need the Fingerprint Based Search.
- Fax application to the number listed on the form and request it be faxed back to 580-928-9827 (WTC Sayre).
- Purpose of Request is *Health Careers Class*.

_____ **Attend (One) Mandatory Parent Meeting** – Select one of the following:

January 25 from 5:30 – 6:00
January 25 from 6:30 – 7:00
January 26 from 5:30 – 6:00
January 26 from 6:30 – 7:00

Health Careers Certification – Sayre Campus
Cost List: 2024 – 2025

Included in cost of tuition:

The Language of Medicine – 13th Edition	$88.49
The Human Body in Health and Disease – 8th Edition	$64.49
Health Careers Today – 7th Edition	$83.99
Phlebotomy – 6th Edition	$70.49
Long Term Care – 5th Edition	$38.25
Career Safe Voucher	$32.00
HOSA State and National Dues	$25.00

**Textbooks are provided for WTC student use. Purchasing personal copies is optional but Not required.*

Supply List Purchased by the student / Not included in the cost of Tuition:

Before School (Do not purchase anything until you have been accepted to the program!)	
Clinical Uniform (Scrubs)	2 sets of steel gray scrubs **These must worn to class Monday through Friday – starting the first day of school.
Nursing shoes	White non-canvas shoes (walking or nursing type shoes, must be closed-toed and heel)
Watch	must have a sweep second hand- no Apple watches
General school supplies	Calculator, 2gb Flash Drive, Earbuds or headphones, Pens, pencils, highlighters, notebook, binder, 1 box of Kleenex
After School Starts | Before Competition or Clinicals	
OSBI Background Check	*due before clinical rotations for students 18 years or older
10 Panel Drug Screen	*due before clinical rotation
HOSA uniform	1 pair of slacks, white button-up shirt, and closed-toed dress shoes
Accidental Insurance	$15.00 – Required for Adults only

Available Licensure or Certifications:

Optional certification costs could include but are not limited to the following:

Basic Life Support - CPR	Free (1st year)
Certification tests for Long-Term Care	$90.00 (1st year)
CTTC Phlebotomy Technician	Free (2nd year)

WTC Board of Education allows $100 per year to be used for student certification testing!! To be eligible, students must maintain a B-average, 90% attendance rate, be active in HOSA, and be in good standing at WTC.

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Documentation of Volunteer Hours

To be Completed by the Student:

Name of Volunteer _____

Name of Medical Facility _____

Facility Phone Number _____

Facility Address _____

_____

Name of Facility Contact

To be Completed by Facility Contact:

Date	# of hours	Description of assistance given

Comments

Signature

Thank you for allowing our potential students this experience.

Health Careers Certification – Sayre Campus

Parental and Student Consent Statement:

The undersigned hereby understand, consent and agree as follows:
We understand that health care education program has experiences in laboratory and clinical environments that use equipment, scientific instrumentation, chemicals and biologicals when under ideal laboratory conditions may involve a degree of risk which is probably greater than ordinarily encountered in daily life and which certainly could involve greater risk if used improperly. We also understand that the laboratory and clinical personnel are mindful that they have special obligations and responsibilities to exercise care and attention in the instruction and supervision of our son/daughter and in excluding them from activities they believe to be inherently dangerous or inappropriate to their experience level.
Our son/daughter will be required to attend a laboratory and clinical safety instruction course and will be taught and/or supervised in the proper handling of such equipment, instrumentation and materials to minimize risk.

We understand that this program is not an "introductory" class, but rather, a program to prepare the student for success in the healthcare field. This program consists of a **self-paced, discovery learning type curriculum**. The instructor is a facilitator to assist the student to explore a variety of resources to solve problems to gain knowledge needed to complete the objectives of the course.

Students will be part of the local, state, and national chapters of Health Occupation Students of America (HOSA). Dues are the students' responsibility
We understand the student should have the following skills, characteristics and attributes in order to be successful in this program:

- Understanding that remediation is available for those who need it, students should have at least 10th grade levels in the areas of reading, comprehension, and mathematics.
- **Student must be a "self-starter".** The student must be able to work through the curriculum on his/her own. Each student will work toward their own goal at their own pace though there are benchmarks to assure that the student progresses toward their goal of completion, certification and employment.
- **Students must be able to work well with others** on group projects or study sessions.
- Students may be required to lift or transfer up to 25 pounds or work on the floor, stand at a workstation or sit at a workstation typical to those in the healthcare field.
- Students that have a felony you may not be able to be employed in the healthcare field.
- Students who would not be likely to acquire the necessary credentials to work in the healthcare field may not be successful in HCCS.
- Students will be required to comply with health and safety regulations that include dress code, immunizations and background check. **Costs are the students' responsibility.**
- The board has the right to deny a license to an individual with a history or criminal background, disciplinary action on another health-related license or certification or judicial declaration of mental competence. These cases are considered on an individual basis at the time application for licensure is made with the exception of felony or sex offender status. An individual with a felony conviction cannot apply for licensure for at least five years after completion of all sentencing terms, including probation and suspended sentences, unless a presidential or gubernatorial pardon is received [59 O.S. 567.6]

I, the undersigned, acknowledge that **I have requested the opportunity to be a student** in the Health Careers Certification program at Western Technology Center, Sayre Campus. I understand that if accepted, I will be subject to **certain rules and regulations** concerning safety, the clinical facility, and general decorum and conduct. I also understand that this arrangement is by invitation and that the needs and plans of the Technology Center and the clinical facility where I am assigned may change or **require termination of the arrangement at any time.** *I agree that I will follow the policies and procedures that are outlined in the student handbook, or I may be dismissed from the program and if I am a high school student I will have to return to my home high school for the remainder of the school year.*

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Applicant **Date**

WTC – Burns Flat Campus
621 Sooner Drive
Burns Flat, OK 73624
Phone: (580) 562-3181
Fax: (580) 562-4476
Email: kwedel@westtech.edu

Educating People for Success

WTC – Sayre Campus
2002 Northeast Highway 66
Sayre, OK 73662
Phone: (580) 928-2097
Fax: (580) 928-9827
Email: jpartain@westtech.edu

LETTER OF REFERENCE

To be completed by Applicant:

Applicant Name _____ **Date** _____ **Program** **Health Careers**
(Please Print) **Circle Campus** Burns Flat / **Sayre**

Applicant's Release of Information: I give my permission to release information to Western Technology Center concerning my qualifications for entrance into a skills-based program, and I agree to hold blameless the person being requested to complete and return this form.

_____ _____
Signature of Parent Signature of Applicant

To be completed by the Reference. ***Please return form to the High School Counselor OR appropriate campus above.***

Please complete the following checklist based upon your experience with the applicant listed above. **Please be honest**. Do *not* return this form to the applicant; information is confidential and will be kept secure.

Check the box that best describes the individual performance characteristics for each of the dimensions or traits listed. Thank you for your time.

Dimensions or Trait	Exceeds Standard	Meets Standard	Below Standard
Judgment and Problem Resolution			
Tolerance for Stress			
Teamwork			
Communication Skills			
Attention to Detail and Organization			
Initiative			
Appropriate Appearance and Demeanor			
Graciously Accepts Criticism and Suggestions			
Attendance and Punctuality			
Additional Comments:			

Individual Completing Reference:

Name _____ **Title or Position** _____
Place of employment _____ **Relationship to Student** _____
Mailing Address _____ **Phone** _____

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Graciously Accepts Criticism and Suggestions			
Attendance and Punctuality			
Additional Comments:			

Individual Completing Reference:

Name _____ **Title or Position** _____
Place of employment _____ **Relationship to Student** _____
Mailing Address _____ **Phone** _____

AM PM FT

Admission Checklist: HEALTH CAREERS

Applicant Name _____ **School:** _____ **GR:** 11 12 A

ITEM TO BE COMPLETED	DATE RECEIVED	Notes
WTC Application Form (online)		
Consent Form		
Shot Record (must include HepB)		*TB will be required after winter break.*
Reference Letter 1		
Reference Letter 2		
Reference Letter 3		
Essay (typed and include name!)		
Volunteer Hours at a Medical Facility		
Background Check (18+ only)		
COMPLETION DATE:		
Mandatory Parent Meeting	Yes / No	

FOR OFFICE USE ONLY			
Notes:	AM	PM	Waitlist
Committee Member Signature: _____			

OKLAHOMA STATE BUREAU OF INVESTIGATION

Criminal History Record Information Request
6600 North Harvey Place
Oklahoma City, OK 73116
(405) 848-6724
(405) 879-2503 FAX
https://osbi.ok.gov/

Type Of Search Requested:

- ☒ Name-Based - $15.00
- ☒ Sex Offender - $2.00
- ☒ Mary Rippy Violent Offender - $2.00
- ☐ State Fingerprint-based - $19.00*

VIA mail or in-person ONLY. Must provide ORIGINAL fingerprint card. DO NOT FAX. Includes name-based search.

DATE _____

Request Submitted via:

☐ Fax ☐ Mail ☐ In Person

REQUESTS WILL BE RETURNED IN THE MANNER RECEIVED.

Mail requests should include postage-paid reply envelope.

Fax requests must include payment by credit card and a dedicated Fax Phone Line for return of completed search:

(580) 928-9827

DO NOT FAX FINGERPRINT CARDS

ACCEPTABLE FORMS OF PAYMENT: ☐ CASH ☐ CASHIER'S CHECK / MONEY ORDER

☐ BUSINESS CHECK ***No Personal Checks Accepted.*** ☐ CREDIT CARD ***For Visa, MasterCard and Discover, security code is 3 digits on back of card. For Amex, security code is 4 digits on front. These are the only cards accepted.***

CREDIT CARD # _____ EXPIRATION DATE _____ SECURITY CODE _____

CARD HOLDER _____

Please print the name of the individual card holder as it appears on the credit card.

CARD HOLDER SIGNATURE (REQUIRED) _____

REQUESTOR INFORMATION: **(Type or print clearly in blue or black ink)** *Results will only be returned to the original requestor*

REQUESTOR'S NAME _____ _____

SIGNATURE OF REQUESTING PARTY

STREET ADDRESS _____

_____

CITY STATE ZIP

PHONE NUMBER _____ E-MAIL ADDRESS _____

Requestors outside of the United States are strongly encouraged to provide an e-mail address for purposes of correspondence.

PURPOSE OF REQUEST Health Careers program entry at Western Technology Center

SUBJECT INFORMATION: **(Type or print clearly in blue or black ink)**

Forms with corrections made with white out or by striking through the fields in this section will not be processed.

NAME _____

LAST FIRST MIDDLE

ALIAS/MAIDEN NAME(S) _____ _____ _____

MAXIMUM OF THREE ALIAS NAMES PER REQUEST

DATE OF BIRTH _____ (MM/DD/YYYY). *If date of birth is unavailable, include exact age of subject.*

RACE _____ SEX _____ SOCIAL SECURITY NUMBER _____

SEARCH RESULTS (*Please do not write in the spaces below*):

Oklahoma State Bureau of Investigation Computerized Criminal History	Oklahoma Department of Corrections Sex Offender	Oklahoma Department of Corrections Violent Offender

Unless fingerprint cards are provided, record information is furnished solely on the basis of name or description similarity with the subject of your inquiry.
For questions on the Sex Offender / Violent Offender Registry, please contact the Oklahoma Department of Corrections.