



## Conviction/Criminal History Disclosure Form

<b>This form must be completed to be considered for Allied Health Programs admission and continuation</b>			
<p>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.</p> <p>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.</p> <p>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.</p>			
First Name:	Last Name:	SID:	
Have you ever been convicted of any of the following crimes? If <b>YES</b> , please check all that apply and provide detailed information in section VI.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Arson (1 <sup>st</sup> Degree)	Custodial Interference (1 <sup>st</sup> , 2 <sup>nd</sup> Degree)	Prostitution	
Assault (Custodial)	Extortion (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	Promoting Prostitution (1 <sup>st</sup> Degree)	
Assault (Simple or 4 <sup>th</sup> Degree)	Forgery	Rape (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	
Assault (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	Incest	Rape of a Child (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	
Assault of a child (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	Indecent Exposure (Felony)	Robbery (1 <sup>st</sup> , 2 <sup>nd</sup> Degree)	
Burglary (1 <sup>st</sup> degree)	Indecent Liberties	Selling/Distributing Erotic Material to a Minor	
Child Abandonment	Kidnapping (1 <sup>st</sup> , 2 <sup>nd</sup> 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 (1 <sup>st</sup> , 2 <sup>nd</sup> Degree)	Theft (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	
Child Molestation (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> Degree)	Murder (Aggravated)	Unlawful Imprisonment	
Communication with a Minor	Murder (1 <sup>st</sup> , 2 <sup>nd</sup> Degree)	Vehicular Homicide	
Criminal Abandonment	Patronizing a Juvenile Prostitute	Violation of Child Abuse Restraining Order	
Criminal Mistreatment (1 <sup>st</sup> , 2 <sup>nd</sup> Degree)	Promoting Pornography	Or Any of These Crime That May Have Been Renamed	
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.			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide detailed information in Section VI.
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?			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide detailed information in

	Section VI.
Have you been debarred, excluded or otherwise ineligible for participation in federal health care programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide detailed information in Section VI.
Have you ever had your license as a health care practitioner revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please provide detailed information in Section VI.
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>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.</b></p> <p><b>Authorization for Repeat Background Checks and Dissemination of Results:</b> 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-</p>	

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	
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**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

		YES	NO		YES	NO
1. Have you ever had an illness that:	YES	NO		7. Do you have any problems standing for long periods? Or walking? Ability to lift 50 lbs or more	___	___
a. Required you to stay in the hospital?	___	___		8. Do you wear glasses or contacts?	___	___
b. Lasted longer than a week?	___	___		9. Have you ever had a heart murmur, high blood pressure, or a heart abnormality?	___	___
c. Is related to allergies? (i.e. hay fever, hives, asthma, insect stings)	___	___		10. Do you have any allergies to any medicine? If yes, what? _____	___	___
d. Required an operation?	___	___		11. Do you have any skin conditions? Particularly arms and/or hands	___	___
e. Is chronic? (asthma, diabetes, anemia, epilepsy)	___	___		12. Are you missing a kidney?	___	___
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?	___	___		13. Any psychological illness? Are you currently being treated If so, what medication? _____	___	___
If yes, please indicate: Site of injury _____ Type of injury _____				14. <b>For Women:</b> 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? _____		
a. Required you to go to an emergency room or to see a doctor?	___	___		15. Are you worried about any problem or condition at this time? If yes, please explain: _____ _____	___	___
b. Required to stay in the hospital?	___	___		16. Year of Last Complete Physical? _____		
c. Required x-rays?	___	___		17. Is there a family history of: Diabetes, Polycentric Kidneys, Congenital Heart Disease, Hypertension, Breast Cancer, GI Cancer, etc.? Who? _____ _____ _____		
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?	___	___				

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 PRACTITIONER 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

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**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*

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**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.)

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**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

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

2<sup>nd</sup> 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**

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

**CHEST X-RAY:** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reading: \_\_\_\_\_

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**OUTCOME (check only one):**

- |  |   |
|--|---|
| _____ LTBI treatment prescribed            | _____ Patient being evaluated as a TB suspect             |
| _____ No treatment needed (not infected)   | _____ Patient refused treatment                           |
| _____ No treatment indicated (low TB risk) | _____ Treatment not advised due to high risk of hepatitis |
| _____ Treatment deferred due to _____      | _____ Previously treated for TB or LTBI                   |
|  | _____ Other _____   |

**Follow-up/Comments (include treatment regimen):**

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Provider Signature

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Provider Name (please print)

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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.



**STUDENT HANDBOOK ACKNOWLEDGEMENT**

I have read the Renton Technical College Student Handbook (accessible on-line at [www.rtc.edu](http://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: \_\_\_\_\_