Surgical Technology Program
Directions for Completing the Application
2013-2014

Thank you for applying to the Surgical Technician program at the Ossining Extension Center of Westchester Community College. The 9-month, non-credit, day program provides students with core sciences, surgical technician specialty content, lab and clinical externship hours. The program meets Mondays-Thursdays from 8:30am-2:30pm. This course includes 408 hours of didactic and lab content and 54 Clinical days/382 clinical hours. In total our students complete 790+ program hours over 9 months. Students are eligible to take the National Health career Association (NHA) certification exam for the Certified Operating Room Surgical Technician (CORST) credential.

1. Complete and mail application for admission with the non-refundable $25 application fee. Checks or money orders should be made out to “Westchester Community College.” The recommendation may be submitted at a later date, but must be received before the first day of class. Mail the completed application to

   Westchester Community College
   Ossining Extension Center
   22 Rockledge Avenue
   Ossining, New York 10562
   Attn: Surgical Technology Program

2. Complete top half of recommendation form and submit to individual who will be completing the reference, along with an addressed, stamped envelope. The envelope should be addressed to the address identified in #1 above.

3. Once you have been admitted to the program, obtain a physical examination from a licensed physician and submit the physical examination record. This form must be submitted no later than October 14, 2013. You do not need to mail the physical examination record with application.

4. Once your application is received, you will be scheduled for an interview and the remaining steps in the application process. All candidates must successfully complete the entire application process to be eligible for the program. The Surgical Technology Program has limited enrollment, and the application process is selective.
5. The application for the fall 2013 Surgical Technology Program is due on or before August 1 2013. The program is scheduled to start on October 14, 2013. Classes are held on Monday thru Thursday from 8:30am-2:30pm. Tuition Payment Options: The tuition for the Program is $7640.75. This tuition may be paid in full by October 1, 2013* or may be paid by module according to the following schedule:

- Module 1 Payment $1194.25 Due on or before 10/01/13
- Materials Fee-1 $500.00 Due on or before 11/04/13
- Module 2 Payment $1186.00 Due on or before 12/09/13
- Module 3 Payment $1194.25 Due on or before 01/07/14
- Module 4 Payment $1186.00 Due on or before 03/11/14
- Module 5 Payment $1186.00 Due on or before 04/22/14
- Module 6 Payment $1194.25 Due on or before 06/10/14

Students must successfully complete all modules, fulfill all academic requirements, and financial responsibilities to Westchester Community College in order to be eligible to take the Certification Examination.

6. Additional Program Fees/Costs:

- Application Fee: $25.00
- Books $300.00 (approx.)
- Malpractice Insurance $15.00
- Certification Exam $225.00

Refunds
- For requests received at least 2 business days prior to the start of the class: 100% refund.
- There are no refunds after that.

All refund requests must be made to the college in writing or emailed to continuinged@sunywcc.edu. If you paid by check, please allow 6-8 weeks for your refund to be processed. Credit card refunds are processed immediately.

*The number of individuals accepted into the Surgical Tech Program is limited. For those individuals accepted into the Program, payment for Module 1 is due no later October 01, 2013. If payment is not made by 10/01/13, your seat in the Surgical Technology Program will not be held.
Surgical Technology Program
Westchester Community College-Ossining Extension Center
Application for Admission 2013-2014

Please complete all of the following, and print or type clearly.

Today’s Date: __________________________

Social Security Number __________________ Date of Birth __________ Sex: Male or Female

Last Name ___________________________ First Name ___________ Middle Initial __________

Legal Street Address ____________________________ ____________________________

City ___________________________ State ___________________________ Zip Code __________

Home Phone Number (Area Code + Number) ____________________________ Business or Cell Phone Number (Area Code + Number) ____________________________

E-Mail ____________________________ $ ____________________________

Application Fee Enclosed ($25.00)

Are you a U. S. Citizen? ☐ YES ☐ NO

Do you have a permanent resident card? ☐ YES ☐ NO

Authorization to work or stamped passport? ☐ YES ☐ NO

Do you have a high school diploma/GED ☐ YES ☐ NO

If yes, date issued: ____________________________

List college(s) or institution(s) attended and degree earned: ____________________________

Degree/Credits: ____________________________
Surgical Technology Program
Recommendation Form (total of 3)

TO THE APPLICANT:
Fill in all information in this section and forward this form to the recommender. The recommender must return the completed form to Westchester Community College, Ossining Extension Center, 22 Rockledge Ave, Ossining, NY 10562, Attention: Surgical Technology Program. For the convenience of the recommender, you should include an addressed, stamped envelope. The reference must be from someone who is familiar with your professional work and/or career goals. References are not acceptable from relatives, in-laws, or friends.

Please print:

Name: ____________________________________________
  Last           First          M.I.

Applicant’s Signature __________________________________

TO THE RECOMMENDER:

Thank you for providing information regarding the individual above; she/he is applying for enrollment in the Surgical Technology Program at Westchester Community College-Ossining Extension Center.

Please Print: ____________________________________________
  Last Name           First Name          M.I.

Organization: ______________________________________________

Address: __________________________________________________

(Area Code) Phone # ________________________________________

Relationship to the applicant __________________________________

Signature: _________________________________________________

Please see reverse side
Name of the applicant: ____________________________________________________________

Please evaluate the applicant by checking the appropriate spaces below:

<table>
<thead>
<tr>
<th>Qualifications</th>
<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to work with doctors, nurses, and other members of a health care team</td>
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<tr>
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<tr>
<td>4. Written communication skills</td>
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<td>5. Punctuality</td>
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Please feel free to add any additional comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature ___________________________ Date: ___________________________
Surgical Technology Program
Recommendation Form

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Please print:

Name: ____________________________________________________________

Last First M.I.

Applicant’s Signature _____________________________________________

____________________________________________________________________

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Last Name First Name M.I.

Organization: ______________________________________________________

Address: _________________________________________________________

(Area Code) Phone #_______________________________________________

Relationship to the applicant _________________________________________

Signature: _________________________________________________________

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<td>15. Punctuality</td>
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</tr>
</tbody>
</table>

Please feel free to add any additional comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature __________________________ Date: ____________
Surgical Technology Program
Ossining Extension Center
Physical Examination Record 2012-2013

Applicant: Please complete the information requested below (including your signature, and then give the form to your medical provider so that your health status can be documented. Thank you.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

New York State Health Code 405, requires that this ANNUAL Physical Examination Report form be fully completed and on file Ossining Extension Center BEFORE the start of the program. Failure to comply will result in suspension without refund from clinical classes. The affiliating agency may ask to see copies of this report.

According to New York State Law, you may be tested for drugs and alcohol abuse. The use of drugs and alcohol can jeopardize your student status in the medical curricula.

### ALL LABORATORY AND TITER REPORTS MUST ACCOMPANY THIS RECORD

- **Hepatitis B Core Antibody Results:**
  - OR
  - **Hepatitis Vaccine Series:**
    - 1) Date
    - 2) Date
    - 3) Date

<table>
<thead>
<tr>
<th>Blood Titer*</th>
<th>Titer: Numerical Value</th>
<th>Immune</th>
<th>Non-Immune</th>
<th>Immunization **</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td>Date/Signature of Medical Provider</td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Varicella</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* Returning Students ONLY: if original titers showed immunity; there is no need to repeat them

** Immunization is required if titers show non-immunity

### Tuberculosis Screening

<table>
<thead>
<tr>
<th>Annual PPD Test:</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

If PPD is positive; a chest x-ray is required. Please enclose report.

<table>
<thead>
<tr>
<th>Chest x-ray results:</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
</table>

Tetanus Vaccine:

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

Tetanus Vaccine must have been administered within the past 10 years

PLEASE COMPLETE THE REVERSE SIDE
<table>
<thead>
<tr>
<th>Age:</th>
<th>Sex:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height:</td>
<td>Weight:</td>
</tr>
<tr>
<td>Blood Pressure:</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Examination-Description, Comments, and/or Recommendations**

<table>
<thead>
<tr>
<th>Vision</th>
<th>Heart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing</td>
<td>Abdomen</td>
</tr>
<tr>
<td>Nose</td>
<td>Kidneys</td>
</tr>
<tr>
<td>Throat</td>
<td>Extremities</td>
</tr>
<tr>
<td>Teeth</td>
<td>Reflexes</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Current Medications:</td>
</tr>
<tr>
<td>Lungs</td>
<td>Comments:</td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
</tr>
</tbody>
</table>

Is this student physically and emotionally able to participate in the curriculum of his/her choice, which involves classroom and laboratory activities and clinical practice? If not, please specify:

________________________________________________________

**Pursuant to:**
Health Facilities Series: H-40
Subject: Revised Part 405 Hospitals - Minimum Standards

This examination is of sufficient scope to ensure that the examined student of this date, is able to assume his/her duties free from a health impairment, which is of potential risk to the student. The patient served by the student or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances, which may alter the individuals behavior.

EXAMINING HEALTH CARE PROVIDER  
Signature  
Please Print Name

DATE: ____________________________

ADDRESS: ____________________________

TELEPHONE: ____________________________

The contents of this report are confidential; information will be released only by court order or written consent of individual identified on this form

Ossining Extension Center  
22 Rockledge Avenue  
Ossining, New York 10562
Telephone: 914-606-7400  
Fax: 914-606-7401  
E-Mail: Ossining@sunywcc.edu
The U.S. Occupational Safety and Health Administrator (OSHA) issued a new Blood borne Pathogens Standard in December 1991. The rule applies to all employers who have workers that may come in contact with blood or other body fluids during the performance of their job, putting them at risk of contacting highly contagious viral infections. Health Science student, because of the nature of their occupational training, may also be at risk of contacting these same blood borne infections.

Bloodborne pathogens include the Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV) which causes AIDS. HBV is a potentially life-threatening virus. The CDC (Centers for Disease Control) estimates there to be approximately 280,000 HBV infections each YEAR IN THE United States, about 8,700 of these includes health care workers.

The observation of Universal Precaution technique and the utilization of protective clothing and equipment may prevent exposure to potentially infectious materials. However, the best defense against Hepatitis B Virus is vaccination. Although it is not a medical requirement, it is strongly recommended that you consider being vaccinated.

If anytime you are exposed to a blood borne pathogen, a report of the incident MUST be filed with the clinical affiliate, curriculum chairperson and the student Health Services Office.

PLEASE COMPLETE:

I understand that due to occupational exposure to blood or other potentially infectious materials, I may be at risk of contacting the HBV infection.

I have been informed of the importance and benefits of the HBV vaccination and it has been strongly recommended that I be vaccinated. Please indicate your status/decision regarding hepatitis B vaccination:

1. Begun/Completed Vaccination Series:

   Vaccination Dates: 1) _________  2) _________  3) _________

2. My signature indicates that I have decided not to be vaccinated at this time.

   __________________________________________  ________________________
   Signature                                      Date

Please return this form to:
Westchester Community College
Ossining Extension Center
22 Rockledge Avenue
Ossining, NY 10562
ATTN: Surgical Technology Program
Telephone: 914-606-7400
FAX: 914-606-7401