Ossining Extension Center
Integrated Patient Care Technician Program
Application Process 2013

The integrated patient care technician program (IPCT) is a 120-hour program designed to prepare Certified Nursing Assistants to serve as Patient Care Technicians (PCTs). PCTs who function as multi-skilled care providers in a variety of health-care settings. The program is designed to prepare an individual to work in hospital, long-term care, or skilled nursing facilities. The program provides the CNA the opportunity to gain additional skills to be prepared to perform routine patient care treatments including simple lab tests, EKG’s, simple dressing changes, phlebotomy, current technology. The technician will receive education on standard and universal health care precautions; therapeutic communication techniques, English and math skills, customer service, and patient care delivery systems. Upon successful completion of the program, students are eligible to take the Certified Patient Care Technician exam offered by the National Health career Association (please be prepared to pay a separate fee of $149 for the exam online at NHAnow.com).

Prerequisite:
In order to be eligible for the Integrated Patient Care Technician program, individuals must have a valid license as a Certified Nurse Assistant in New York.

Costs
The cost for the program is $1438.25, which may be paid in full or in one payment of $493.25, and two payments of $470 paid before the start of each module. Please see payment schedule for module dates.

<table>
<thead>
<tr>
<th>Module</th>
<th>Cost</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module I</td>
<td>$493.25</td>
<td>Sept 17, 2013</td>
</tr>
<tr>
<td>Module II</td>
<td>$470.00</td>
<td>Oct 22, 2013</td>
</tr>
<tr>
<td>Module III</td>
<td>$470.00</td>
<td>Nov 19, 2013</td>
</tr>
</tbody>
</table>

There are additional fees for this program that include:
1. Non-refundable application fee of $25
2. $15 malpractice insurance due in the first module payment
3. Additional Costs: Text books, fee for certification exam, CPR, background and drug checks, transportation to externship site, and any additional supplies or uniforms.

Start date, module dates, and general schedule
The integrated patient care technology program will start on Tuesday September 17, 2013. The program will end on December 20, 2013.
Classes are held on Tuesdays/Fridays 4:30pm-9:30pm. The three modules will be as follows:

<table>
<thead>
<tr>
<th>Module</th>
<th>Start Date</th>
<th>End Date</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module I</td>
<td>Sept 17-Oct 17, 2013</td>
<td>Oct 22-Nov 14, 2013</td>
<td>T/F 4:30pm-9:30pm</td>
</tr>
<tr>
<td>Module II</td>
<td>Oct 22-Nov 14, 2013</td>
<td>Nov 19-Dec 19, 2013</td>
<td>T/F 4:30pm-9:30pm</td>
</tr>
</tbody>
</table>

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.
***You must successfully complete all three modules including the externship, pass the National Certification examination for the Patient Care Technician (CPCT), and complete all financial obligations of the program to become a Certified Patient Care Technician. ***

1. Individuals interested in this credential must submit an application packet containing the following documentation by August 16, 2013:
   - A completed Integrated Patient Care Technician application
   - Copies of certificates of course completion for: the Certified Nursing Assistant Program
   - A valid New York State Certified Nurse assistant registration (other states CNA certifications may be submitted for consideration, but are not guaranteed acceptable for this requirement)
   - $20 application for admission non-refundable fee. Please make out check or money order to “Westchester Community College”

The completed packet must be submitted to:

The Ossining Extension Center, Westchester Community College
22 Rockledge Avenue, Ossining, NY 10562
Attn: C. Jones

2. Complete the top half of the recommendation form and submit to each reference person. Please make sure they understand you need the document submitted in a timely fashion so that it is here by August 16, 2013. Please give them stamped envelope that is addressed with the address listed above so they can return it easily.

3. Once your application is received, you will be screened. You will be scheduled for an interview and reading exam if appropriate. All candidates must successfully complete the screening interview prior to acceptance to the program.

Requirements due prior to start of externship:
Before the externship starts, students are responsible for:

1. Providing a copy of current CPR certification
2. Paying for both the malpractice insurance through the college and paying for school insurance.
3. Registering, paying for, and providing results for both a background check and the drug test from CertifiedBackground.com.
4. Submitting the Integrated Patient Care Technician Physical Examination Record form. Obtain a physical examination from a licensed physician and submit the physical examination record before the externship starts.
5. Submitting any additional tests, forms, or clearance procedures as required by the externship site.
6. Acquiring the appropriate shoes and or uniform as stipulated by the externship site.
7. Fulfilling all attendance and payment requirements of the program.

Westchester Community College adheres to the policy that no person on the basis of race, color, creed, national origin, age, gender, sexual orientation, or handicap is excluded from, or is subject to, discrimination in any program or activity.
Integrated Patient Care Technology Program
Westchester Community College-Ossining Extension Center

Application for Admission Fall 2013

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) ___________________________

$ ___________________________

Application Fee Enclosed

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: __________________________________________ ___________________________
Integrated Patient Care Technology Program
Recommendation Form

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: IPCT 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 ____________________________ Date: ____________________________

TO THE RECOMMENDER:

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

Name of Recommender: (Please Print):

Last Name: ____________________________ First Name: ____________________________

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 adults &amp; children as clients in a health care setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Perseverance</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Verbal communication skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Written communication skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Punctuality</td>
<td></td>
<td></td>
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<tr>
<td>6. Ability to work with others as a team (co-workers)</td>
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<td></td>
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</tr>
</tbody>
</table>

Please feel free to add any additional comments:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Signature ___________________________ Date: _________________

Please return the completed form to: Westchester Community College, Ossining Extension Center, 22 Rockledge Ave, Ossining, NY 10562, Attention: IPCT Program

Or Fax to: 914 606-7401
Integrated Patient Care Technology Program
Recommendation Form

TO THE APPLICANT:

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Please print:

Name: ____________________________________________

Last ____________________________ First ____________________________ M.I ____________________________

Applicant’s Signature ____________________________________________ Date: ______________

________________________

TO THE RECOMMENDER:

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

Name of Recommender: (Please Print):

Last Name: ____________________________________________ First Name: ____________________________

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>
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<th>Excellent</th>
<th>Good</th>
<th>Average</th>
<th>Below Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Ability to work with adults &amp; children as clients in a health care setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Perseverance</td>
<td></td>
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<td></td>
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<tr>
<td>9. Verbal communication skills</td>
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</tr>
<tr>
<td>10. Written communication skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Punctuality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Ability to work with others as a team (co-workers)</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please feel free to add any additional comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature ________________________________ Date: ________________

Please return the completed form to: Westchester Community College, Ossining Extension Center, 22 Rockledge Ave, Ossining, NY 10562, Attention: IPCT Program

Or Fax to: 914 606-7401
Integrated Patient Care Technician Program

Ossining Extension Center
Physical Examination Record 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) ___________ 2) ___________ 3) ___________

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

<table>
<thead>
<tr>
<th>Tuberculosis Screening</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>** Annual PPD Test:**</td>
<td>** Tetanus Vaccine:**</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Result</td>
<td></td>
</tr>
</tbody>
</table>

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

Chest x-ray results:

Date ____________________ Result ____________________

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

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**Pursuant to:** State of New York Department of Health memorandum, series 88-66, 3/22/88  
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.
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 contracting highly contagious viral infections. Health Science student, because of the nature of their occupational training, may also be at risk of contracting these same blood borne infections.

Blood borne 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