North Central
MICHIGAN COLLEGE
1515 Howard Street • Petoskey, Michigan 49770

Application:
Allied Health Programs

Please PRINT or TYPE: Application Date:_________________

Program Applying for:

_____ **EMS/Paramedic** (by July 1 for Fall admission)

_____ **Medical Assistant** (by March 1 for Fall admission; October 1 for Winter admission)

_____ **Phlebotomy** (by July 1 for Fall admission)

_____ **Surgical Technologist** (by July 1 for Fall admission, odd years)

North Central Student Number: ______________________________ WOCTEP Student ____Yes _____No

Name in Full: ____
Last First Middle

Home Address: ____
Number and Street City State Zip

Home Phone: _______________ Alternate Phone: _______________ E-mail: ___________________________________

Social Security No.:__ __ __ - __ __ - __ __ __ __ Date of Birth: ____

In case of emergency, notify: ____
Name Phone Alternate Phone

Give information concerning high school(s) attended or G.E.D.:

Name of school City & State

____

____

Give information concerning college, university, vocational schools, allied health schools attended:

Name of Institution City & State Number of Credits Earned Dates Attended

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Admission Checklist

It is the student's responsibility to: Return this application and all items in the Admission Checklist to the Department of Allied Health, 1515 Howard Street, Petoskey, MI 49770. Applications and documentation may be returned in person or by mail. If you need further assistance, please call 231.348.6696.

- ☐ Completed Allied Health Program Application
- ☐ Proof of high school graduation or G.E.D.
- ☐ Official copies of College Transcripts, other than North Central Michigan College, if applicable to both Student Services and Department of Allied Health
- ☐ A copy of current Basic Life Support (BLS) for Healthcare Providers
- ☐ Completed Pre-Admission Medical History Form
- ☐ All applicants must provide a copy of written documentation from a Health Care Provider for these specific immunizations:
  - ☐ Proof of Varicella (Chicken Pox) immunity as shown by (a) physician documented history of disease (b) documentation of two immunizations **or** (c) a serum titer confirming immunity.

    AND
  - ☐ Proof of (a) a complete (3 injection series) Hepatitis B Vaccination **or** (b) a serum titer confirming immunity.

    AND
  - ☐ Proof of (a) **two** Measles Vaccinations (may be part of MMR) **or** (b) a serum titer confirming immunity **or** (c) proof the student was born prior to January 1, 1957 **or** immunity as shown by (d) physician documented history of disease.

    AND
  - ☐ Proof of (a) one Mumps vaccination (may be part of MMR) **or** (b) a serum titer confirming immunity **or** (c) proof the student was born prior to January 1, 1957 **or** immunity as shown by (d) physician documented history of the disease.

    AND
  - ☐ Proof of (a) one Rubella Vaccination (may be part of a MMR) **or** (b) a serum titer confirming immunity **or** immunity as shown by (c) physician documented history of disease, **regardless of date of birth**.

    AND
  - ☐ Proof of Tetanus-Diphtheria vaccination within the last 10 years.
  - ☐ Proof of Tuberculosis-A negative TB test repeated annually.

Students with incomplete applications, as reflected by missing items from the checklist, will not be considered for selection into the program. For additional information visit NCMC website or contact Student Services.

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or falsification of information is cause for denial of admission or expulsion from the College. I understand that the information contained in this application will be read by the faculty and staff of the NCMC Nursing and Allied Health programs. I understand that my signature below specifically authorizes the NCMC Nursing and Allied Health programs to conduct a criminal history and background check.

____ ________________________

Signature of Applicant **Date**

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Allied Health Programs

Visit/Volunteer/Work Experience Statement

(to be completed by applicant **and** applicant's supervisor)

Instructions: Applicants who wish to have career visit, shadowing, volunteer or paid work experience considered as part of their ranking for admission into certain North Central Michigan College Allied Health Programs must complete this statement with the supervisor of the experience to be considered. These experiences may be used in the ranking process to the extent that they are verifiable by Program contact with the supervisor listed and directly relate to the Allied Health Program indicated. Decisions concerning the applicability of the experience are made by the Allied Health Admissions Committee and are final. Incomplete or unsigned statements will not be considered.

Applicant Information (to be completed by applicant):

Date: ________________________________

Applicant Name: ____ Student No: ___________________________

I am applying to:

___ Emergency Medical Services ___ Medical Assistant ___ Phlebotomy ___ Surgical Technologist

Supervisor Information (to be completed by supervisor):

Thank you for agreeing to help us rank this applicant for one of our Allied Health programs! The applicant listed above has identified you as someone qualified to comment on his or her experiences with you in a career visit/shadowing opportunity, a volunteer experience, or a paid work experience. Please indicate below which of these categories best describes your interaction with the applicant, and the amount of time you spent together:

____ Career Visit/Shadowing How much time did applicant spend with you? ____

____ Volunteer Experience How much time did applicant spend with you? ____

____ Paid Work Experience How long did applicant work with you? ____

Please describe the nature of your contact with the applicant. Attach additional sheets as necessary.

____

____

____

____

____

____ ____
(Signature) (Printed Name)

____ ____
(Phone) (E-mail)

Return this form to: Director of Allied Health, North Central Michigan College, 1515 Howard St., Petoskey, MI 49770

For North Central Use Only:

Admission Points Awarded: _________

PRE-ADMISSION MEDICAL HISTORY

Admission Requested for: NSG____ EMS____ MA____ PHLB____

Completion of this form is required for admission to the Allied Health programs.
Instructions – Complete Part I and II of this form before going to your physician.

____M_____ F_____ Date of Birth ___________
Last Name First Middle

Home Address____ Telephone _________________
Number Street City State Zip

PART I PERSONAL HISTORY

1. Check if you ever had or now have any of the following conditions.
   Rheumatic Fever___ Tuberculosis___ Diabetes___ Diptheria___ Epilepsy___ Hernia___
   Asthma___ Gland Trouble___ Scarlet Fever___ Kidney Disease___ Convulsions___
   Nervous Tendencies___ Recurrent Headaches___ Speech Disorder___ Back Injury___

   Explain any conditions you have checked: ____
   ____

2. Have you ever been a patient in a hospital? ____________If yes, explain _____________________
   ____

3. Are you now under medical care? ____________________If yes, explain _____________________
   ____

4. Do you take any medication regularly? ________________If yes, please list ___________________
   ____

5. Do you have hospitalization insurance? _______________ Insurance Company ________________
   ____Policy No. _________________________

In submitting this health record, I certify that I have given accurate information to the best of my knowledge.

Students Signature ____ Date __________

Parent or Legal Guardian Signature___________________________________ Date __________
(Students under 18 years)

PART II EMERGENCY INFORMATION

In case of emergency, the following person may be contacted:

Name____ Phone _______________________
Alternate Phone _______________________

It is the policy of North Central Michigan College to offer admission, housing, employment, campus activities and financial aid without regard to race, color, national origin, religion, sex, sexual orientation age, height, weight, Marital status or disability.

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PART III MEDICAL EXAMINATION

This section completed by the Physician. Please return to: North Central Michigan College
Department of Allied Health • 1515 Howard Street • Petoskey, MI 49770

Height Weight	Blood Pressure S________________ D________________	TB Test or Chest X-Ray Date ___________________________________ Results __________________________________	Vision RT______ LT______	Hearing RT______ LT______

	Normal	Abn.		Normal	Abn.		Normal	Abn.
Nutrition			Throat			Abdomen		
Skin			Thyroid			Varicose Veins		
Posture			Heart			Feet		
Mouth			Lungs & Chest			Hemorrhoids		
Ears			Breasts			Nervous System		
Nose			Pelvic			Menses		

Describe abnormal findings: (Use separate letter if comprehensive report is necessary)
Is there any mental, emotional or physical condition for which the student should remain under observation?
____
____

Please explain any conditions which you consider significant in the personal history____________________
____

Is the student physically qualified to participate in activities related to Health Care? Yes _______ No ______
Comments: ____
____

Consultation recommended? Please indicate: ____
____

How long has this applicant been under your supervision? _____________________________________

Required of all applicants:
Applicants to Allied Health Programs must have current documented immunizations, or verifiable proof of past history or a serum titer confirming immunity. *Chickenpox (Varicella), *Tetanus/Diptheria, Measles/Mumps/Rubella, Polio, Hepatitis B (HBV)*

*Tetanus should be within last 10 years. In addition, the following immunization is strongly recommended for persons in the health care fields. You should discuss this with your physician: *Yearly Influenza*

Signature of Physician ____
Name Degree Date

Please Print
Name____
Address ____
Street and Number City State Zip Office Phone