2016–2017
Pharmacy Technician

Admissions Information
Specific Program Requirements
Directory

Admissions Office
Western Iowa Tech Community College
4647 Stone Avenue
P.O. Box 5199
Sioux City, Iowa  51102-5199
Phone: 712-274-6403 or
       800-352-4649
Fax: 712-274-6412
E-mail: info@witcc.edu
Website: www.witcc.edu

Financial Aid Office
712-274-6403 or
800-352-4649

Program Advisors:
Teri Peterson, RN, BSN
712-274-8733, Ext. 1421
E-mail: teri.peterson@witcc.edu
Office: Advanced Sciences Building, Room L314
Western Iowa Tech Community College
Pharmacy Technician
Program Overview and Opportunities

The pharmacy technician diploma program will prepare students for entry-level pharmacy technician positions in both the institutional and community pharmacy setting. The role of the pharmacy technician is one of the fastest growing fields in medical care. A pharmacy technician is an individual who, under the supervision of a pharmacist, assists in the day-to-day pharmacy operations that do not require the professional judgment of a pharmacist. Pharmacy technicians may perform many of the same duties as a pharmacist; however, all of their work must be checked by a pharmacist before medications can be dispensed to a customer or patient. A central defining feature of the technician’s job is accountability to the pharmacist for the quality and accuracy of his or her performance.

Preparing medications involves using sterile and nonsterile techniques to count, measure, and compound drugs. Additional duties of the pharmacy technician include: receive and verify written prescriptions, take prescription refill requests, prepare IV medications, operate computer and automation systems, apply prescription and auxiliary labels to medication bottles, control and price inventory, order supplies, restock shelves, prepare insurance claim forms, and operate cash registers.

Students must achieve a minimum of a 2.0 GPA in all program requirements. Graduates are eligible to take the National Pharmacy Technician Certification Examination. This exam is voluntary in many states; however, successful completion of the exam demonstrates a standard competency level of the individual to function in the role of a pharmacy technician throughout the United States.
IOWA CORE PERFORMANCE STANDARDS

Iowa Community colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution’s ADA Policy.

<table>
<thead>
<tr>
<th>CAPABILITY</th>
<th>STANDARD</th>
<th>SOME EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL INCLUSIVE)</th>
</tr>
</thead>
</table>
| Cognitive-Perception        | The ability to gather and interpret data and events, to think clearly and rationally, and to respond appropriately in routine and stressful situations. | Identify changes in patient/client health status  
Handle multiple priorities in stressful situations |
| Critical Thinking           | Utilize critical thinking to analyze the problem and devise effective plans to address the problem | Identify cause effect relationships in clinical situations  
Develop plans of care as required |
| Interpersonal               | Have interpersonal and collaborative abilities to interact appropriately with members of the healthcare team as well as individuals, families and groups. Demonstrate the ability to avoid barriers to positive interaction in relation to cultural and/or diversity differences. | Establish rapport with patients/client and members of the healthcare team  
Demonstrate a high level of patience and respect  
Respond to a variety of behaviors (anger, fear, hostility) in a calm manner  
Nonjudgmental behavior |
| Communication               | Utilize communication strategies in English to communicate health information accurately and with legal and regulatory guidelines, upholding the strictest standards of confidentiality. | Read, understand, write and speak English competently  
Communicate thoughts, ideas and action plans with clarity, using written, verbal and/or visual methods  
Explain treatment procedures  
Initiate health teaching  
Document patient/client responses  
Validate responses/messages with others |
| Technology Literacy         | Demonstrate the ability to perform a variety of technological skills that are essential for providing safe patient care. | Retrieve and document patient information using a variety of methods  
Employ communication technologies to coordinate confidential patient care |
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting, supporting, and/or transferring a patient/client.</td>
<td>The ability to propel wheelchairs, stretchers, etc. alone or with assistance as available</td>
</tr>
<tr>
<td>Motor Skills</td>
<td>Gross and fine motor abilities to provide safe and effective care and documentation</td>
<td>Position patients/clients Reach, manipulate, and operate equipment, instruments and supplies Electronic documentation/keyboarding Lift, carry, push and pull Perform CPR</td>
</tr>
<tr>
<td>Hearing</td>
<td>Auditory ability to monitor and assess, or document health needs</td>
<td>Hears monitor alarms, emergency signals, auscultatory sounds, cries for help</td>
</tr>
<tr>
<td>Visual</td>
<td>Visual ability sufficient for observations and assessment necessary in patient/client care, accurate color discrimination</td>
<td>Observes patient/client responses Discriminates color changes Accurately reads measurement on patient client related equipment</td>
</tr>
<tr>
<td>Tactile</td>
<td>Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature and texture</td>
<td>Performs palpation Performs functions of physical examination and/or those related to therapeutic intervention</td>
</tr>
<tr>
<td>Activity Tolerance</td>
<td>The ability to tolerate lengthy periods of physical activity</td>
<td>Move quickly and/or continuously Tolerate long periods of standing and/or sitting as required</td>
</tr>
<tr>
<td>Environmental</td>
<td>Ability to tolerate environmental stressors</td>
<td>Adapt to rotating shifts Work with chemicals and detergents Tolerate exposure to fumes and odors Work in areas that are close and crowded Work in areas of potential physical violence Work with patients with communicable diseases or conditions</td>
</tr>
</tbody>
</table>
Pharmacy Technician Diploma
Program of Studies and Estimated Costs

<table>
<thead>
<tr>
<th>Catalog #</th>
<th>Course Title</th>
<th>Credit Hrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHR 105</td>
<td>Intro to Pharm Tech</td>
<td>3</td>
</tr>
<tr>
<td>HSC 114</td>
<td>Medical Terminology</td>
<td>3</td>
</tr>
<tr>
<td>BIO 163</td>
<td>Essentials of Anatomy &amp; Physiology</td>
<td>4</td>
</tr>
<tr>
<td>MAT 772</td>
<td>Applied Math</td>
<td>3</td>
</tr>
<tr>
<td>SPC 122</td>
<td>Interpersonal Communication</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td><strong>Total First Semester</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Catalog #</th>
<th>Course Title</th>
<th>Credit Hrs.</th>
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</thead>
<tbody>
<tr>
<td>PHR 120</td>
<td>Pharmacology for Pharm Tech</td>
<td>3</td>
</tr>
<tr>
<td>PHR 947</td>
<td>Pharmacy Tech Practicum</td>
<td>1</td>
</tr>
<tr>
<td>HSC 122</td>
<td>English/Spanish Medical Terminology</td>
<td>3</td>
</tr>
<tr>
<td>PSY 111</td>
<td>Introduction to Psychology</td>
<td>3</td>
</tr>
<tr>
<td>PHI 105</td>
<td>Introduction to Ethics</td>
<td>3</td>
</tr>
<tr>
<td>ADM 105</td>
<td>Introduction to Keyboarding</td>
<td>1</td>
</tr>
<tr>
<td>HSC 245</td>
<td>Team Building</td>
<td>1</td>
</tr>
<tr>
<td>BCA 115</td>
<td>Internet Basics</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total Second Semester</strong></td>
<td><strong>16</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Program Total</strong></td>
<td><strong>32</strong></td>
</tr>
</tbody>
</table>

Pharmacy Technician Certificate
Program of Studies and Estimated Costs

<table>
<thead>
<tr>
<th>Catalog #</th>
<th>Course Title</th>
<th>Credit Hrs.</th>
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</thead>
<tbody>
<tr>
<td>PHR 105</td>
<td>Intro to Pharm Tech</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td><strong>Total First Semester</strong></td>
<td><strong>3</strong></td>
</tr>
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<td>Pharmacy Tech Practicum</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total Second Semester</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Program Total</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
College Policies

Please refer to the student handbook and the college catalog for information or policies related to:

- Discrimination, Sexual Harassment, Americans with Disabilities Act Compliance
- Sexual and Gender Harassment
- Discrimination
- Discipline
- Disability
- Release of Student Information
- Drug-Free College Community
- Transfer Students
- Financial Aid and Payment Options

_The college handbook and the college catalog information may be acquired on-line at witec.edu and then click on student services; or, a printed copy can be requested or acquired at the main Sioux City Campus Enrollment Services Office._

**Student Insurance Overview**

**Malpractice Insurance** – Students are highly encouraged to obtain their own individual coverage.

**Student Accident and Health Insurance** – From the Student Handbook: “WITCC does not have a compulsory insurance plan, but the College recommends that students enroll in a voluntary group accident and/or health insurance plan available through commercial insurance companies.” Insurance information is made available to students attending orientation sessions and is available in Enrollment Services. College liability insurance is _not_ a substitute for health or accident insurance.  _It is highly recommended that students obtain their own health insurance coverage._

**Student Workers’ Compensation Insurance** – Students are covered by WITCC workers’ compensation insurance if they are injured while participating in a school-to-work program. Examples of school-to-work programs include job shadowing, internships, mentoring, training agreements, apprenticeships, and other work experiences through community placements. If an accident or injury occurs while participating in a school-to-work program, students must seek their own medical care. A Personal Injury/Medical Emergency Form must be completed and turned in to the WITCC Board Secretary. Additional information required with the completed form includes: Physician Summary (why was the treatment sought, what was done, and rationale for treatment) and all receipts for medications and medical services. WITCC submits claims to the workers’ compensation insurance company. The company reviews all claims and determines eligibility.

**Academic Advising**

Academic advising assists students in realizing the maximum educational benefits available by helping them to better understand themselves and to learn to use the resources available at WITCC to meet their specific educational needs.

Don Young, Program Coordinator, will be your advisor throughout the program.

**Role of Student in Advising**

The student is to contact his or her advisor regarding all academic issues. It is necessary to make advance appointments with advisor for efficiency in scheduling.

The student is ultimately responsible to meet **all** requirements for graduation.

**Pharmacy Technician Clinical Program Requirements**

1. All students must submit to a criminal and abuse background check and be cleared before starting their program clinical experience.
2. All students must submit all health screening paperwork and be cleared by Mercy Business Health Services.
3. All students must sign a confidentiality agreement before beginning their clinical experience.
Clinical Participation Requirements

WITCC uses external affiliated agencies for clinical experiences for our students. Affiliated agencies may impose requirements for students in order that they be allowed access to clinical experience.

- **Students may be required to provide the following information to external affiliated agencies:**
  * Health Screening/Immunizations
  * CPR
  * Mandatory Reporter
  * Criminal and Abuse Background Checks
  * Drug Test

- The **student should maintain copies** of the documents listed above. *Affiliating agencies may require the student to provide a copy of the documentation.*

- **Drug Testing**
  Students may need to consent for drug testing and release of that information to external affiliating agencies for clinical experience. Western Iowa Tech Community College is uncertain of what other drugs may be screened.

- Unprofessional conduct, breach of confidentiality, or performing duties beyond the scope of practice or academic preparation is grounds for immediate removal from the clinical site. Removal will result in failing clinical and may include disciplinary action.

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**NOTICE AND RELEASE - READ CAREFULLY BEFORE SIGNING**

I, the undersigned student in a health occupations program at Western Iowa Tech Community College, understand that participation in a clinical experience is part of the health occupations program and that participation in a clinical experience includes working at an affiliating agency. I further understand that affiliating agencies have the right to establish requirements for participation in clinical experience. I understand that I am responsible for providing copies of the documentation requested by the affiliated agency. I understand and agree that if I am rejected for participation in a clinical experience by an affiliating agency or if I refuse to submit to checks or tests that are required by an affiliating agency in order to participate in a clinical experience, I may be unable to complete my program of study and graduate from a health occupations program. I hereby release Western Iowa Tech Community College, its employees, and all affiliating agencies from any liability with regard to my participation in a clinical experience and decisions made concerning my participation in a clinical experience.

Print name: ____________________________________________________________________________

Student’s Name ________________________________________________________________________ Program __________________________ Date __________

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STATE OF IOWA Criminal History Record Check Request Form

DCI Account Number: 
(if applicable)

To: Iowa Division of Criminal Investigation

From: Western Iowa Tech Community College

647 Stone Ave PO BOX 5199
Sioux City, IA 51102-5199

Phone: 712-274-6400 ext. 1405
Fax: 712-274-6471 (CONFIDENTIAL)

I am requesting an Iowa Criminal History Record Check on:

<table>
<thead>
<tr>
<th>Last Name (mandatory)</th>
<th>First Name (mandatory)</th>
<th>Middle Name (recommended)</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth (mandatory)</th>
<th>Gender (mandatory)</th>
<th>Social Security Number (recommended)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Male ☐ Female

Waiver Information: Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature: ________________________________

Iowa Criminal History Record Check Results (DCI use only)

As of _________________, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI #_______________
  DCI initials _________
Waiver Information:

Iowa law does **not** require a waiver. However, without a signed waiver from the subject of the request any arrest over 18 months old, **without** a final disposition, cannot be released to a non-law enforcement agency.

Deferred judgments where DCI has received notice of successful completion of probation also cannot be released to non-law enforcement agencies without a signed waiver from the subject of the request.

If the “No Iowa Criminal History Record found with DCI” box is checked, it could mean that the information on file is not releasable per Iowa law without a waiver.

General Information:

The information requested is based on **name** and **exact date of birth only**. Without fingerprints, a **positive** identification cannot be assured. If a person disputes the accuracy of information maintained by the Department, they may challenge the information by writing to the address on the front of this form or personally appearing at DCI headquarters during normal business hours.

The records maintained by the Iowa Department of Public Safety are based upon reports from other criminal justice agencies and therefore, the Department cannot guarantee the completeness of the information provided.

The criminal history record check is of the Iowa Central Repository (DCI) **only**. The DCI files do not include other states’ records, FBI records, or subjects convicted in federal court within Iowa.

In Iowa, a **deferred judgment is not** considered a conviction once the defendant has been discharged after successfully completing probation. However, it should be noted that a deferred judgment may still be considered as an offense when considering charges for certain specified multiple offense crimes, i.e. second offense OWI. If a disposition reflects that a deferred judgment was given, you may want to inquire of the individual his or her current status.

A **deferred sentence is** a conviction. The judge simply withholds implementing a sentence for a certain probationary period. If probation is successful, the sentence is not carried out.

Any questions in reference to Iowa criminal history records can be answered by writing to the address on the front of this form or calling (515) 725-6066 between 8:00 a.m. and 4:00 p.m., Monday - Friday.

**REMINDER** - (1) Send in a separate Request Form for each last name, (2) a fee is required for each last name submitted, (3) a completed Billing Form must be submitted with all request(s).

Iowa law requires employers to pay the fee for potential employees’ record checks.
Please read and sign the following confidentiality statement

Confidentiality Agreement

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), it is the policy of WITCC that confidentiality and privacy of information is of utmost importance for health occupations students. Confidential information is any client, physician, employee, and business information obtained during the course of your clinical experiences associated with WITCC. Please read and sign the following confidentiality statement.

I will treat all confidential information as strictly confidential, and will not reveal or discuss confidential information with anyone who does not have a legitimate medical and/or business reason to know the information. I understand that I am only permitted to access confidential information to the extent necessary for client care and to perform my duties. Information that may be construed as a breach of confidentiality includes but is not limited to:

1. client’s name
2. client’s diagnosis
3. type of care being provided
4. reason for seeking health care services, treatment, and response to treatment
5. personal problems or actions

I will not access, use or disclose confidential information in electronic, paper, or oral forms for personal reasons, or for any purpose not permitted by agency policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at all agencies to gain access to my own confidential patient information.

In preparing papers, presentations, and other course work I will de-identify protected health information. I will not remove any individually identifiable health information from the facilities in which I am completing my clinical experience.

I agree to use all confidential information and the information systems of the facilities I am assigned in accordance with facility policy and procedure. I also understand that I may use my access security codes or passwords only to perform my duties and will not breach the security of the information systems or disclose or misuse security access codes or passwords. I will also make no attempt to misuse or alter the information systems of the facilities in any way.

I understand that I will be held accountable for any and all work performed or changes made to the information systems or databases under my security codes, and that I am responsible for the accuracy of the information I input into the system. I understand that violation of such policies and procedures may subject me to immediate termination of association with any facility, as well as civil sanctions and/or criminal penalties.

Any student who fails to maintain confidentiality and/or directly violates confidentiality may risk expulsion from the program in which they are enrolled.

I have read and understand the WITCC confidentiality policy and agree to abide by the policy as written above.

Print name: ____________________________________________

Student Signature ______________________________________ Date ________________
Health Evaluation

To provide a safe and healthy environment for yourself and those you will come into contact with, you must complete a health evaluation prior to entering the clinical phase of your education. **If these requirements are not completed, you will not be allowed to participate in the clinical rotation.** Western Iowa Tech Community College has contracted with Mercy Business Health Services to assist in evaluating the completion of this health evaluation.

**Health Evaluation includes:**
Health history, hearing, vision, immunization record, and physician physical.

**Current Vaccinations:**
You must provide proof that your vaccination status is current. Dates must accompany the physical; just listing “current vaccinations” will not satisfy the requirements. If you are unsure of your vaccination status, you should have your immunizations updated.

**Hepatitis B:**
You must show documentation of either:
1. Receiving the Hepatitis B Vaccine (a series of three shots for the prevention of Hepatitis B, a disease of the liver);
2. Decline to Accept Form;
3. OR that you are currently receiving the series by providing a photocopy of the consent verifying the process.
If you are planning to start the vaccine at a later date, sign the Decline to Accept Form and submit it.

**Tuberculosis Test:**
Because of the increased incidence of tuberculosis, each student is required to have a current T.B. skin test. The T.B. skin test is valid for **one year**.

**Completed Records:**
The completed records will be reviewed. If there is need for additional information or tests, you will be contacted. **Please make a copy of your health evaluation for your own records. In the future, copies will not be made available for you.**

Please complete the health evaluation in its entirety and return promptly by email to **Marilyn West, RN, BSN; Western Iowa Tech Community College; marilyn.west@witcc.edu**. You may contact Marilyn at **712-274-8733, Ext. 1256**. Your health evaluation is considered current for two years. If the course of your education extends past two years, your health evaluation must be repeated.

Mercy Business Health Services is available if you should have questions, if you need help finding a physician, or if you would like us to provide you with vaccinations. You may contact Mercy Business Health Services at **233-5155**, Monday through Friday, 8:00 a.m. to 4:30 p.m.
WITCC Clinical Health Evaluation

Name: ____________________________  Last Name (Please Print)  First Name  Middle Initial

Date of Birth: ___________ E-mail: ____________________________ Program of Study: ______________

Do you have any known allergies?  Yes ○ No ○ If yes, list all known allergies: ____________________________

Student Signature: ____________________________ Date: ____________________________

Health Care Provider Complete The Following

Immunizations:

<table>
<thead>
<tr>
<th>MMR #1:</th>
<th>MMR #2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles titre results:</td>
<td>Mumps titre results:</td>
</tr>
<tr>
<td>Rubella titre results:</td>
<td>Date Given:</td>
</tr>
<tr>
<td>Tetanus/Diphtheria (valid if within 10 years): #1:</td>
<td></td>
</tr>
<tr>
<td>#2:</td>
<td>#3:</td>
</tr>
<tr>
<td>Hepatitis B titre results:</td>
<td></td>
</tr>
<tr>
<td>Chickenpox titre results:</td>
<td></td>
</tr>
</tbody>
</table>

**Titre results must include numerical value – not just “positive, negative, immune”.

#1 Tuberculin Skin Test-Mantoux 5 TU/PPD (valid if within one year) Given: ________ Read: ________
PPD result (state reaction in mm): ________ Professional Signature: ____________________________

#2 Tuberculin Skin Test-Mantoux 5 TU/PPD (valid if within one year) Given: ________ Read: ________
PPD result (state reaction in mm): ________ Professional Signature: ____________________________

Questions:

#1 - Have recommendations for limited physical activity been made? ○ Yes  ○ No
If “Yes”, for how long and why? ____________________________

#2 - Do you recommend this individual for full participation in clinical?  Yes ○  No ○
If “No,” please comment: ____________________________

Health Care Provider Name (please print): ____________________________

Health Care Provider Signature: ____________________________ Date: ____________________________

Address: ____________________________ Phone #: ____________________________

How to Submit WITCC Clinical Health Evaluation

Scan all information as a PDF document and e-mail to: Marilyn.West@witcc.edu. The weekly deadline is 7am Friday morning. All information received by the weekly deadline will be reflected in a class update sent to your instructor the following Monday morning.
Mercy Business Health

To: All WITCC Health Occupation Students
From: Marilyn J. West RN BSN

To provide a safe and healthy environment for you and those you will come in contact with, you must submit a completed WITCC Clinical Health Evaluation prior to your first day of clinical. You will not be cleared to participate in clinical until your WITCC Clinical Health Evaluation is complete. Below are answers to the most commonly asked questions. If you have any further questions, please feel free to contact me at Marilyn.West@witcc.edu

Student Information
Be sure to answer all personal information on the top of the WITCC Clinical Health Evaluation.

Health Care Provider Complete The Following
This part of your WITCC Clinical Health Evaluation is to be completed by a medical doctor, a nurse practitioner or a physician’s assistant. No other forms will be accepted.

Measles/Mumps/Rubella (MMR) – You will need to provide one of the following:
• two vaccination dates.
• positive titre for measles, positive titre for mumps and a positive titre for rubella.

Tetanus/Diphtheria (Td) – A Td is current for 10 years.

Chickenpox – You will need to provide one of the following:
• two vaccination dates.
• positive titre.

Hepatitis B (Hep B) – You will need to provide one of the following:
• vaccination dates.
• positive titre.
• signed decline form.

Tuberculin Skin Test (TST) – An initial baseline two-step TST is required. The second TST can be given one week to one year after the first TST as long as the first TST has not expired. A TST is current for one year. The first and second TST must be turned in before the start of clinical. If you have had a past positive TST, you will need to provide documentation of a negative chest x-ray. If the negative chest x-ray is more than one year old, you will also need to turn in a TB Symptom Assessment form.

Please make sure that you keep a copy of your WITCC Clinical Health Evaluation for your own records. In the future, a copy will not be made available to you!
Information About Hepatitis B Vaccine

NOTE: This form should be discussed with the physician of your choice, signed and returned with all other health forms.

The Disease
Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of infected patients. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people develop chronic active hepatitis and cirrhosis. HBV also appears to be associated with the development of liver cancer.

The Vaccine
Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of purified, inactivated Hepatitis B antigen. It has been extensively tested for safety and efficiency in large scale clinical trials with human subjects. A high percentage of healthy people who receive three doses of vaccine achieve protection against Hepatitis B. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine. Full immunization requires 3 doses of vaccine over a six-month period, although some persons may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects
The incidence of reported side effects is low. A small percentage of persons receiving the vaccine experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain, and mild fatigue have also been reported. Few cases of serious side effects have been reported with the vaccine, including Guillain-Barre Syndrome, although the possibility exists that more serious side effects may be identified with more extensive use.

You may check with your insurance company concerning coverage.

If you have any questions about Hepatitis B or the Hepatitis B vaccine, please discuss with your physician.

Consent Form

I have discussed with my physician and have read the above statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand that I must have 3 doses of vaccine to confer immunity. However, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me. My decision is voluntary. I understand that all arrangements for receiving the vaccine are my responsibility.

<table>
<thead>
<tr>
<th>Date</th>
<th>Lot #</th>
<th>Site</th>
<th>Nurse</th>
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<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Name of Person to Receive Vaccine (Please Print)  

__________________________  (1)  __________  __________  __________

Signature of Person Receiving Vaccine  

__________________________  (2)  __________  __________  __________

Date Signed  

__________________________  (3)  __________  __________  __________
Information About Hepatitis B Vaccine

NOTE:  This form should be discussed with the physician of your choice, signed and returned with all other health forms.

The Disease
Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of infected patients. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people develop chronic active hepatitis and cirrhosis. HBV also appears to be associated with the development of liver cancer.

The Vaccine
Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of purified, inactivated Hepatitis B antigen. It has been extensively tested for safety and efficiency in large scale clinical trials with human subjects. A high percentage of healthy people who receive three doses of vaccine achieve protection against Hepatitis B. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine. Full immunization requires 3 doses of vaccine over a six-month period, although some persons may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects
The incidence of reported side effects is low. A small percentage of persons receiving the vaccine experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain, and mild fatigue have also been reported. Few cases of serious side effects have been reported with the vaccine, including Guillain-Barre Syndrome, although the possibility exists that more serious side effects may be identified with more extensive use.

You may check with your insurance company concerning coverage.

If you have any questions about Hepatitis B or the Hepatitis B vaccine, please discuss with your physician.

Decline to Accept
I have discussed with my physician and have read the above statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand the benefits and risks of the Hepatitis B vaccine and I do not wish to receive the vaccine.

Name of Person Declining Vaccine (Please Print)

Signature of Person Declining Vaccine

Date Signed

RETURN EMAIL TO:
Marilyn West, RN, BSN
Western Iowa Tech
Community College
marilyn.west@witcc.edu
Signature Sheet of Understanding

I have reviewed and understand the Pharmacy Technician Program Admission Information Booklet and agree to abide by these policies.

Print name: __________________________________________

Signature ___________________________________________ Date _____________________