



# **Medical Assistant Program**

## **MA Student Forms**

Revised: 2017

Seattle Vocational Institute  
Statement of Acknowledgement -  
Washington State Background Check Outcomes  
Medical Assistant Program

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Seattle Vocational Institute (SVI) does not discriminate in any course or program of study. The current Washington State requirement is for Medical Assistants to be eligible for certification as a Healthcare Professional with the State. However, a conviction or convictions (felony or misdemeanor) or unacceptable Washington State Patrol and/or National Criminal Background Check may prevent me from being certified as a Healthcare Professional with the State of Washington.

I also understand that felony conviction(s) or other conviction(s), may prohibit me from taking a national certification examination. Current Washington state legislation requires all Medical Assistants to be certified at the national level which in turn qualifies them to apply for Washington state level certification. It is necessary for Medical Assistants in Washington State to be certified at the national and state level to be eligible for employment as a Medical Assistant.

I therefore authorize Seattle Vocational Institute to perform a Washington State Patrol Criminal Background check on me as required by our practicum sites so that we do not place a student with a conviction or convictions with our practicum partners.

I understand that it is at the discretion of the practicum partners to accept or deny an externship opportunity.

Finally, I understand that Seattle Vocational Institute's responsibility is to provide me with training in my chosen field, and to inform me of any known obstacles to my success in that field. Seattle Vocational Institute does not guarantee employment. – Medical Assistant Program Disclosure – Background Check

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I, \_\_\_\_\_, acknowledge that I  
have been informed by Seattle Vocational Institute representative,

\_\_\_\_\_, that if the result of my  
Criminal Background Check indicates criminal history, I may not be able to be placed in an approved Medical Assistant practicum "externship," resulting in non-completion of the Medical Assistant Program at Seattle Vocational Institute.

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*Student signature*

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*date*

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*SVI Representative Signature*

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*date*

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Verification of Receiving the MA Handbook”*

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I (Print student name), \_\_\_\_\_ have received and agree to abide by the requirements and policies of the Seattle Vocational Institute MA program as defined in the MA Student Handbook.

- I understand that I will be informed in writing of any change in policy that occurs prior to the next scheduled Handbook revision.
- I understand that I may address any questions/concerns regarding the SVI MA Program Student Handbook to the MA Program Director.

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This disclaimer must be turned in to the Program Director. This Disclaimer will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Hepatitis B Immunization Waiver”*

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I (Print student name), \_\_\_\_\_ have received information regarding the Hepatitis B vaccine provided in the Medical Assistant Handbook.

**After careful consideration of the risks, I do not wish to receive the vaccine.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This disclaimer must be submitted to the Program Director. This Disclaimer will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Consent for Participation in Injections, Blood Draws and Other Clinical Activities”*

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To develop expertise in the administration of injections, blood draws and other clinical less invasive procedures, it is necessary that those skills be performed in the college skills clinic and lab setting.

The skills acquired in the practice setting will prepare you for patient care in the clinical area. To facilitate learning you are required to be the subject as well as the provider of subcutaneous, intramuscular, intradermal injections, blood draws and other clinical procedures in the clinic and laboratory setting, under the supervision of the instructional staff.

- **In consideration of being afforded the opportunity to administer subcutaneous, intramuscular, intradermal injections and blood draws, as well as other less invasive procedures to other students, I** (Print student name), \_\_\_\_\_ **agree to participate in this learning experience by serving as a subject for other students.**
  
- **I** (Print student name), \_\_\_\_\_ **acknowledge that risks to my person, including but not limited to bruising, swelling and discomfort may be involved in the injections and blood draws.**
  
- **I** (Print student name), \_\_\_\_\_ **agree to hold Seattle Vocational Institute, my instructors and fellow students harmless from any damages I may suffer as a result of said procedures.**
  
- **I** (Print student name), \_\_\_\_\_ **further agree that I will thoroughly familiarize myself with the techniques and seek guidance/supervision prior to performing any of said procedures on another individual.**

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Print Student Name

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Student Signature

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Date

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

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**Note:** This disclaimer must be turned in to the Program Director. This Disclaimer will remain in your MA student file.

*“Student Health Insurance Responsibility”*

I (Print student name), \_\_\_\_\_ understand that I will be responsible for my own health care coverage and expenses incurred by me while a student in the MA Program at SVI.

- I further understand that if it is necessary for me to receive medical care, including Emergency Room treatment, I will be responsible for any charges incurred.
- Additionally, if my insurance status changes I will inform SVI and complete a replacement Student Health Insurance Responsibility Disclaimer or a Student Health Insurance Waiver Disclaimer.
- I have health insurance through \_\_\_\_\_.

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This disclaimer must be turned in to the Program Director. This Disclaimer will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

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*“Student Health Insurance Waiver”*

I (Print student name), \_\_\_\_\_ understand the importance of health insurance coverage. However, I do not have a valid health insurance and purchasing such a policy would place undue hardship on me.

- **I do not and will not hold the school or any affiliated institution liable for any illness, injury or accident that may be directly related to being a Medical Assistant student at Seattle Vocational Institute, and I will be responsible for any medical fees incurred as a result.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This waiver must be turned in to the Program Director. It will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

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## *“Pregnancy and Invasive Clinical Procedures”*

I (Print student name), \_\_\_\_\_ understand that if I am or become pregnant while I am enrolled in Medical Assistant classes/program at Seattle Vocational Institute, in consideration for being given the opportunity to administer subcutaneous, intramuscular, intradermal injections and blood draws, as well as other less invasive procedures to other students, I agree to participate in this learning experience by serving as a subject for other beginning students.

- **I acknowledge that risks to my person, including but not limited to bruising, swelling and discomfort may accompany injections and blood draws. I agree to hold Seattle Vocational Institute, my instructors and fellow students harmless from any damages I may suffer as a result of said procedures.**
- **I understand that Seattle Vocational Institute has no financial obligation to me for any costs that I may incur if I am required to repeat any courses due to my separation from the Medical Assistant program.**

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Print Student Name

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Student Signature

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Date



# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

**Note:** This disclaimer must be turned in to the Program Director. It will remain in your MA student file.

## *“Seattle Vocational Institute Medical Assistant Program Confidentiality Statement”*

I (Print student name) \_\_\_\_\_ understand that in the course of the Medical Assistant program I will encounter information that is of a sensitive and personal nature. I acknowledge that information shared in the classroom environment and in the observation of clinical activities must be kept confidential and private.

- *In the classroom* students are encouraged to participate openly and may choose to share personal information. I understand the shared information is to be held in confidence. **I understand that I may not discuss any information about any student with anyone in or outside of the classroom.**
- *During the clinical practicum portion of my program* I will be involved in various aspects of patient care. I acknowledge that I may have access to information that, by law, must **not** be shared or discussed with anyone other than the patient’s medical providers. I further agree to comply with any additional confidentiality requirements that my clinical site may require of me.

In accordance with current federal and state mandates designed to “develop security standards to prevent unauthorized use or disclosure of any health information that is electronically maintained or used in electronic transmission,” I also acknowledge that any access I have to written or electronic medical charting is strictly confidential. I further acknowledge that should I have access to such record maintenance systems, **I will not attempt to review confidential material in any regard other than by direct order from a supervisor, physician or other health care provider.** Additionally, I acknowledge that I must comply with any confidentiality and regulatory compliance standards that may be imposed upon me during any of my clinical activities.

**I acknowledge that should I break this statement of confidentiality, I may face consequences that may prevent me from completing this program, or other consequences yet to be determined.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

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**Note:** This disclaimer must be turned in to the Program Director. It will remain in your MA student file.

*“Pregnancy and Practicum (Externship)”*

I (Print student name), \_\_\_\_\_ understand that Seattle Vocational Institute does not discriminate in any course; however, if I should become pregnant during my program of study, my pregnancy may effect practicum eligibility.

- **I understand that it is the decision of the practicum site supervisor whether or not I will be allowed to remain on site. If I am asked to leave the site because of pregnancy, it is my responsibility to immediately inform the Seattle Vocational Institute Practicum Coordinator.**
- **If I am receiving Financial Aid at the time I am released from practicum, I understand this may jeopardize my eligibility for future Financial Aid. Furthermore, I may be required to pay back the Financial Aid award I received for the quarter I was serving the practicum.**
- **I understand that Seattle Vocational Institute has no financial obligation to me for any costs that I may incur if I am required to repeat any courses due to my separation from the Medical Assistant program.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

# **DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS**

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# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Separation/withdrawal from the program.”*

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I (Print student name). \_\_\_\_\_ understand that in the event of separation or withdrawal from the program, I will be required to take and pass competency test(s) to advance to the next level of study:

- If after successfully completing Quarter II of the Medical Assistant program and after an absence of six (6) months or more, I will be expected to take and pass the competency tests for Clinical I.
- If after successfully completing Quarter III of the Medical Assistant program and after an absence of six (6) months or more, I will be expected to take and pass the competency tests for Clinical I, Clinical II and Pharmacology.
- If after successfully completing Quarter III and all course work of Quarter IV except for the practicum and after an absence of six (6) months or more, I will be expected to take and pass the competency tests for Clinical I, Clinical II and Pharmacology. Additionally, I will be required to repeat Clinical IV.
- **I understand that Seattle Vocational Institute has no financial obligation to me for any costs that I may incur if I am required to repeat any courses due to my separation from the Medical Assistant program.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This disclaimer must be turned in to the Program Director. It will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Statement of Understanding - High School Diploma / GED”*

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I (Print student name), \_\_\_\_\_, understand that I must have a high school diploma or GED to register in the Medical Assistant program.

Further, I understand that I must achieve 18 years of age prior to the first day of second quarter.

- If an official high school or GED transcript showing evidence of completion is not on file at Seattle Vocational Institute I will not be permitted to enroll in or attend classes in the program.
- If I do not achieve 18 years of age prior to the first day of second quarter I understand that I will not be permitted to attend classes in the Medical Assistant program until I reach age 18.

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This disclaimer must be turned in to the Program Director. It will remain in your MA student file.

# Seattle Vocational Institute Medical Assistant Program Student Information / Emergency Data Sheet

STUDENT ID# (if known) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME (Print) \_\_\_\_\_

ADDRESS

Street \_\_\_\_\_

City, State, zip code \_\_\_\_\_

Phone(s) \_\_\_\_\_

E-mail \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_

RELATIONSHIP TO STUDENT \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER(S) \_\_\_\_\_

IS THERE ANY MEDICAL CONDITION YOU WISH TO SHARE WITH YOUR FACULTY MEMBERS?

\_\_\_\_\_ YES \_\_\_\_\_ NO IF YES PLEASE EXPLAIN \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**Note:** This information sheet must be turned in to the Program Director. It will remain in your MA student file.

# DISCLAIMER FOR MEDICAL ASSISTANT STUDENTS

*“Statement of Understanding – TB, Immunization and Physical Exam Requirement”*

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I (Print student name), \_\_\_\_\_, understand that I am required to have a licensed health care provider complete the information on the Physical Examination Form, including documentation of **TWO** current negative TB tests or a negative chest x-ray for active TB screening.

Further, I agree to provide documentation from a licensed health care provider indicating all required immunizations, as listed on the Physical Examination Form have been verified/received.

- **If the Physical Examination Form and all required documentation is not submitted prior to clinical classes or practicum eligibility I understand that I will not be permitted to attend clinical classes and/or participate in the Medical Assistant program practicum until required documentation is submitted.**

\_\_\_\_\_  
Print Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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**Note:** This disclaimer must be turned in to the Practicum Coordinator or Program Director. It will remain in your MA student file.

# Seattle Vocational Institute Medical Assistant Program Physical Examination

To be completed by a Licensed Provider

Student Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip Code

Date of Exam \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ DOB \_\_\_\_\_

Allergies/drug reactions \_\_\_\_\_

## **HISTORY OF APPLICANT - to be completed by provider (not student)**

Diabetes \_\_\_\_\_

Tuberculosis/respiratory problems \_\_\_\_\_

Epilepsy/convulsions/fainting \_\_\_\_\_

Back problems \_\_\_\_\_

Tremors \_\_\_\_\_

Mental health care \_\_\_\_\_

Medication taken routinely \_\_\_\_\_

Other physical limitations \_\_\_\_\_

## **PHYSICAL EXAMINATION NOTES**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **REQUIRED VISION EXAMINATION**



Vision screening results \_\_\_\_\_ Read fine print w/o corrective lenses? \_\_\_\_ Color blind? \_\_\_\_

A current **two-step** TB test or TB screening chest x-ray is required. **The test or x-ray is considered current if obtained within the past six months.** If not current new TB tests or TB screening chest x-ray is required.

1. Result \_\_\_\_\_mm Positive  or Negative  Date of Results \_\_\_\_\_

2. Result \_\_\_\_\_mm Positive  or Negative  Date of Results \_\_\_\_\_

If a TB test result is positive, a chest x-ray is required and official documentation of results that indicate a negative TB status must be submitted.

*In your opinion, is there any physical, medical, or psychological issue or concern that might prevent this person from participating in the Medical Assistant program?*

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**DOCUMENTATION OF REQUIRED IMMUNIZATIONS**

1) a. Diphtheria-Tetanus immunization date (must be within past 10 years)

\_\_\_\_\_

2) a. MMR immunization dates

\_\_\_\_\_

or

b. MMR titer **with lab results attached**

3) a. Varicella immunization dates \_\_\_\_\_

or

b. History of disease?  YES or

c. Varicella titer **with lab result attached**

4) a. Hepatitis B immunization dates 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_

3<sup>rd</sup> \_\_\_\_\_

b. Hepatitis B titer **with lab result attached**

Signature \_\_\_\_\_

(Licensed Health Care Provider)

Printed Name \_\_\_\_\_

Clinic Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Clinic Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE RETURN THIS FORM TO:**

Seattle Vocational Institute  
Medical Assistant Program  
2120 South Jackson Street  
Seattle, WA 98144

Attn: **MA Program Director/Accreditation Officer**