



Health Tracker Clinical Requirements for

Computerized Axial Tomography

Diagnostic Medical Sonography

Health Care Certificate

Medical Laboratory Technology

Nursing

Occupational Therapy Assistant

Paramedic

Patient Care Medical Assistant

Phlebotomy

Physical Therapy Assistant

Radiologic Technology

Respiratory Care

Surgical Technology

Vascular Sonography

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Clinical Requirements Checklist*

- Criminal Background Check – see *CBC/UDS/HT Instructional Packet*
- Urine Drug Screening – see *CBC/UDS/HT Instructional Packet*
- Castle Branch Compliance Tracker – see *CBC/UDS/HT Instructional Packet*
- GHO Care Learning Modules Transcript
- BLS CPR Certification
- Health Physical completed on HGTC 3-page forms
- 2 Step PPD or QFT Gold Blood Assay
- Seasonal Flu Vaccine (not required for the summer semester)
- COVID Vaccine Card or Medical Exemption or Religious Exemption
- Tdap Vaccine
- Hepatitis B 3- or 2- dose series or + Titer or Declination Waiver
- MMR Titer Lab Results showing your scores with the reference ranges
- Varicella Titer Lab Results showing your score with the reference range
- Liability Insurance Certificate
- Clinical Forms and Disclosures
- Photo to be taken in the Clinical Admissions Office, Speir Bldg., room 1209

*This checklist is for all Nursing and Health Science Students except Dental Hygiene, Dental Assisting, EMT Basic and Massage Therapy.

IMPORTANT NOTES

- Any requirement that will expire mid semester must be completed before the semester begins. Example, your CPR certificate expires in March or your QFT expires in April, you must renew these before classes start in January.
- **CPR Certification** – there are many different types of CPR Certification. **BLS (Basic Life Support) for HealthCare Providers through AHA or ARC ONLY is the certification that is required.**
- One year from the date of your physical, a **physical waiver** may be submitted annually **ONLY** if there has been no change in your health status.
- **2 Step PPD or QFT Gold Blood Assay**
 - A 2 Step PPD is two (2) Tuberculin skin tests. You will visit the physicians/clinics office four (4) times. You have step one administered and then read 48-72 hours later. Seven (7) days later after step one is read, you then have step two administered. Step two is then read 48-72 hours later. There is a max timeframe of 21 days (3 weeks) between Step 1 and Step 2.
 - You may have a QFT Gold Blood Assay in lieu of the traditional skin tests (2 Step PPD). This is a blood draw to test for tuberculosis.
 - After the initial 2 Step PPD or QFT, you will be required to receive a 1 step PPD or QFT Gold Blood Assay yearly. Do not let time lapse or you will need to complete the 2 Step PPD again. Example: If your 2 Step PPD was completed May 1, your annual 1 Step PPD **MUST** be completed no later than May 1 the following year.
- **If your PPD/QFT is positive**, you must have a chest x-ray immediately following the result. A chest x-ray is then required every 2 years.
- **If your PPD/QFT is positive**, a PPD symptom assessment form must be completed yearly.
- **The Seasonal Flu vaccine** is not required for the Summer Semester. It is required for Fall and Spring semesters.
- **The COVID vaccine** is not mandatory to attend HGTC. In order to attend clinicals, though, our affiliates require that you be fully vaccinated (2 Pfizer vaccines 21 days apart, 2 Moderna vaccines 28 days apart or 1 Johnson & Johnson) OR complete ALL the Medical Exemption forms OR complete ALL the Religious Exemption forms.
- **Hepatitis B** - There are 3 options to choose from:
 - Receive the 3-dose series now, 2nd dose in one month, 3rd dose in six months. or 2-dose (HepB) 4 weeks apart. Please check the first box of the Hep B Waiver (page 16), sign, date and upload it along with current dose that states you are in process of receiving the series. *If you received 3 doses in the past, we will accept those as your 3 doses (childhood immunizations).
 - You may have a Hep B Surface Antibody titer to check your immunity. If negative/non-reactive (non-immune), you will need to sign the waiver or begin the 3 series dose. You may use 2 Hep B vaccines from a prior record (childhood, military, etc.) and then just receive a booster to count as the 3rd dose.
 - You may opt out. Please see the Hepatitis Declination Waiver on page 16. Check the second box, sign & date.
- **MMR and Varicella titers are required.** DO NOT go for vaccinations until you have your titers completed. **LAB RESULTS WITH YOUR SCORE AND REFERENCE RANGES ARE REQUIRED FOR MMR AND VARICELLA.** If the titers are positive (immune), you are complete. Simply upload a copy of the positive titer lab results. If negative (non-immune) for the Mumps, Measles or Varicella, 2 boosters/vaccinations are required. Only 1 booster is needed for Rubella. For the 2 boosters, a prior vaccination (childhood, military, etc.) can count as the 1st dose and you will only need to receive the one booster/vaccination. You will need to remit a copy of your immunization record.
- **Liability insurance** – We need the Certificate of Liability, not a copy of the application or proof of payment. If you change programs, your specialty must be changed on your policy. Example, if you are a Phlebotomy student in the spring and then go into the Radiology program for summer, the specialty on your policy must be changed from Phlebotomist to Radiology Technologist.

Completing the below Care Learning modules expedites the orientation process and facilitates the completion of basic regulatory training requirements prior to entering a healthcare facility. To get started, create a new account or re-use your existing account at: <http://passport.carelearning.com>.

- Use **your school issued HGTC email account** when creating your Care Learning account. The program will require you to verify your account during the process.
- You will purchase courses and have access to them for 365 days. The total cost is \$15.00. **The modules must be completed yearly** unless they expire during the semester. If so, you will click on **Repurchase** to complete the updated modules again prior to the start of the semester.
- Below are the **28 modules** that must be completed for Horry-Georgetown Technical College.
- When you **Enter the Classroom**, you **MUST manually ADD these 3 modules** by clicking **Add Courses**:

- **MUSC Health Florence, Marion, Black River Orientation**
- **Tidelands Health – Ebola**
- **Tidelands, Conway, Grand Strand, Waccamaw (GHO)**

✓	Abuse, Neglect, and Exploitation
✓	AIDET
✓	Bloodborne Pathogens
✓	COVID-19: Coronavirus Disease 2019
✓	Culturally Competent Care
✓	Customer Service
✓	Electrical Safety
✓	Emergency Preparedness
✓	Fire Safety
✓	Hand Hygiene
✓	Hazard Communications
✓	HIPAA
✓	Infection Prevention and Control for Non-Clinical Employees
✓	Isolation and Standard Precautions
✓	Lewis Blackman Patient Safety Act

✓	Moving, Lifting and Repetitive Motion
✓	MUSC-Florence, Marion, Black River Orientation
✓	Pain Management
✓	Patients Rights
✓	Population Specific Care: Pediatric
✓	Population Specific Care: The Adult Patient
✓	Sexual Harassment
✓	Slips, Trips, and Falls
✓	TB Prevention
✓	Tidelands Health - Ebola Preparedness
✓	Tidelands, Conway, Grand Strand, Waccamaw – (GHO)
✓	Workplace Diversity
✓	Workplace Violence Prevention

- When all modules are complete, please upload a copy of your transcript to your Castle Branch tracker. →
- If you need technical support, call 866-617-3904 or email support@carelearning.com Monday-Friday 8am-6pm.

Your Name	9/15/2022
✓ Abuse, Neglect and Exploitation	9/15/2022
✓ AIDET	9/15/2022
✓ Bloodborne Pathogens	9/15/2022
✓ COVID-19: Coronavirus Disease 2019	9/15/2022
✓ Culturally Competent Care	9/15/2022
✓ Customer Service	9/15/2022
✓ Electrical Safety	9/15/2022
✓ Emergency Preparedness	9/15/2022
✓ Fire Safety	9/15/2022
✓ Hand Hygiene	9/15/2022
✓ Hazard Communications	9/15/2022
✓ HIPAA	9/15/2022
✓ Isolation and Standard Precautions	9/15/2022
✓ Lewis Blackman Patient Safety Act	9/15/2022
✓ Moving, Lifting and Repetitive Motion	9/15/2022
✓ Patients Rights	9/15/2022
✓ Sexual Harassment	9/15/2022
✓ TB Prevention	9/15/2022
✓ Tidelands Health - Ebola Preparedness	9/15/2022
✓ Tidelands, Conway, Grand Strand, Waccamaw – (GHO)	9/15/2022
✓ Workplace Diversity	9/15/2022
✓ Workplace Violence Prevention	9/15/2022



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

CPR: BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS FORM

CPR REQUIREMENT:

- Basic Life Support Certification for the Healthcare Provider by American Heart Association (AHA) or American Red Cross (ARC) only
- Must renew CPR certification every 2 years

CPR Completion Date:	Certifying Agency:	Instructor's Initials:	
	<input type="checkbox"/> AHA <input type="checkbox"/> ARC		

Certification:

Yes, this student completed the **BLS CPR Certification for Healthcare Providers** through AHA or ARC.

Instructor Printed Name

Instructor Signature

Date

CPR Instructor Affiliation _____

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take this HGTC CPR BLS form with you so your instructor can complete it on your behalf. This form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

Some area CPR/BLS Vendors – Others are also available

Prices and Information Subject to Change

Class Must Be:

BLS (Basic Life Support) Certification for Healthcare Provide
from the American Heart Association or the American Red Cross ONLY

<p>Horry-Georgetown Technical College – Workforce Development – Courtney Sterbenz, Program Manager Cost: \$105.00 (Materials Included) 950 Crabtree Lane, Building 600, Rm 631 Myrtle Beach, SC 29577 courtney.sterbenz@hgtc.edu 843-477-2020 OR 843-477-2079 Dates of CPR classes can be found at www.hgtc.edu/jobtraining under Allied Health.</p>	<p>Horry County Fire & Rescue 2560 Main St Suite 1 Conway, SC 29526 843-915-5190 Melissa Rabonbrownm@horrycountysc.gov Cost: Online Portion - \$32.50 - www.onlineaha.org (Heart Code BLS) In Person Skills - \$15 www.horrycountyfirerescue.com/training</p>
<p>Bless Your Heart - CPR Cost: \$45.00 (Materials Included) 843-457-3305 holly.wittschen@yahoo.com Holly Wittschen</p>	<p>Andy Brown Cost: \$65 Myrtle Beach Area 843-957-0124 ambrown12345@gmail.com</p>
<p>Midway Fire Department Battalion 82 Training Solutions, LLC Pawleys Island / Litchfield Area 843-545-3627 OR 843-267-2300 cgilmore@gtcounty.org OR mfd82@gmail.com http://www.midwayfirerescue.org</p>	<p>Lovely Day Home Care Cost: \$65 225 Lincolnshire Drive Georgetown, SC 29440 843-833-3563 Yejide White Boyd, LPN yegideb@gmail.com</p>
<p>Pee Dee Regional CTC Training Center ID: SC05608 1209 W Evans St Florence, SC 29501-3406 8436654671 carolinacenter@bellsouth.net http://PDCTC.COM</p>	<p>Robeson Community College 5160 Fayetteville Road Lumberton, NC 28360 Kenny Locklear rccems@robeson.edu 910-272-3407</p>
<p>Pee Dee Regional EMS 1314 W Darlington St Florence, SC 29501-2122 8436625771 Kim Dorsett – kim@pdrems.com www.pdrems.com http://www.pdrems.com</p>	<p>Grand Strand Regional Medical Center Class conducted at Coastal Grand Mall 2000 Coastal Grand Cir Suite 520 Myrtle Beach, SC 29577 843-839-9933 Dalena.nguyen2@hcahealthcare.com</p>

All students must be Basic Life Support (BLS) CPR Certified through the American Heart Association (AHA) or American Red Cross (ARC). Certification is offered in two (2) formats, **Blended Learning** and an all **In Person Classroom Training**. For the blending learning, the first portion is completed online. Then the second portion, the hands-on skills assessment, **MUST** be completed in person. If you select one of the vendors above, their class may be the all **In Person Classroom Training**. Therefore, check with the instructor **FIRST** before purchasing the online portion.

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take the HGTC CPR/BLS Form with you so your instructor can complete it on your behalf. The form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed "Student Health Record" prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request.

SECTION I (to be completed by student)

Name: _____
(Last) (First) (Middle)

Other Name(s) Student Known As: _____ Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: _____
(Home) (Cell) (Work)

Medical History:

ALLERGIES: _____

Have you had or do you have? CHECK Yes or NO	Yes	No	Have you had or do you have? CHECK Yes or NO	Yes	No
Rubeola			Stomach/Intestinal Abnormality		
Rubella			Arthritis		
Mumps			Asthma		
Chicken pox (MD documented)			Hay fever		
Infectious Mono			Color blindness		
Positive TB Skin Test			Recurrent headaches		
Recurrent Herpes Viruses			Back problems		
Sexually Transmitted Disease			Organ transplant		
Heart disease			Insomnia		
Heart murmurs			Frequent Anxiety		
Mitral Valve Prolapsed			Frequent Depression		
High Blood Pressure			Worry or Nervousness		
Rheumatic fever			Hepatitis (specify: A,B,C,D,E)		
Diabetes			Epilepsy/Convulsions		
Kidney/Bladder Abnormality			Other (explain below):		

If you check any of these conditions, more information is required in the next section



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

If you checked "Yes" to any medical history on the previous physical page, please give dates and treatments:

Please list any other medical conditions not addressed above:

Please list all medications that you are currently taking:

Student Signature _____ **Date** _____

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____ Respirations: _____ Temp: _____

Corrected Vision: RIGHT: 20/ _____ Hearing: (Please circle)
 LEFT: 20/ _____ RIGHT: Normal Impaired LEFT: Normal Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change, and treatment of ALL findings below)

System	Yes	No	System	Yes	No
Eyes			Musculoskeletal		
Ears			Metabolic/Endocrine		
Nose, throat			Genitourinary		
Neurological			Skin		
Respiratory			Immunological		
Cardiovascular (including murmurs)			Psychiatric		
Gastrointestinal			Other (please explain)		

B. If you have answered "yes" to any item in **A** above, please complete the following: (Additional information may be provided on a separate page identified with student's name).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

**ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION
IN THE NURSING AND HEALTH CARE SCIENCE PROGRAMS**

The following standards are considered essential criteria for participation in the Nursing and Health Science Programs. Students selected for Nursing or one of the Health Science programs must be able to independently engage in educational activities and clinical training activities in a manner that will not endanger clients/patients, other students, staff members, themselves, or the public. These criteria are necessary for the successful implementation of the clinical objectives of the Nursing and Health Science Programs. In order to be admitted, or to be retained in the Nursing or one of the Health Science Programs after admission, all applicants with or without accommodations must:

- **Possess sufficient visual acuity to independently read and interpret the writing of all size.**
- **Independently be able to provide verbal communication to and receive communication from clients/patients, members of the health care team, and be able to assess care needs through the use of monitoring devices, stethoscopes, infusion pumps, fire alarms, and audible exposure indicators, etc.**
- **Possess sufficient gross and fine motor skills to independently position and assist in lifting client/patients, manipulate equipment, and perform other skills required in meeting the needs of nursing care.**
- **The student (Observer) is free of communicable illnesses.**

Does the student have any restrictions/limitations?	Yes	_____	No	_____
If yes, how many weeks are restrictions/limitations in effect:				
If yes, what date will the restrictions/limitations be lifted:				
If yes, will the student be required to follow-up with your office:	Yes	_____	No	_____
If yes, date of scheduled appointment for follow-up:				

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

Print Name of Physician, Physician Assistant, or Nurse Practitioner

Office if Applicable

Signature of Physician, Physician Assistant, or Nurse Practitioner

Date

NOTE: Some NURSING AND HEALTH SCIENCE programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

Your initial Health Science Division – Student Health Physical Record is valid for one year. If you have had no changes in your medical history, you are eligible to complete this Waiver/Notification Form. If you have had any changes in your medical status, you are required to complete a new Health Science Division – Student Health Physical Record.

I, _____, as a student enrolled in a Nursing or Health Science Program at Horry-Georgetown Technical College, do hereby declare that I have sustained no changes in my physical health condition from my most recent student health examination required for the program.

- It is my understanding that in the event a physical health change occurs, it is my responsibility to immediately notify the following individuals of such change(s):
 1. Primary Course instructor and Clinical Instructor
 2. Clinical Admissions Office
- Following notification of health physical change(s), it is my responsibility to:
 1. Make an appointment with a healthcare provider for physical examination and completion of a new Health Science Division – Student Health Physical Record.
 2. Provide the completed Student Health Physical Record to the Clinical Admissions Office for verification of current eligibility for clinical without restrictions (specifically page 3 of health physical).
 3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.
- If restrictions are indicated on the Student Health Physical Record, the Clinical Admissions Office will notify the student’s designated Program Department Chair and/or Dean for guidance regarding further clinical continuation.
- In the event I fail to notify the appropriate individuals of such health changes, Horry-Georgetown Technical College is released from all liability relevant to my physical health status, and such failed actions on my behalf may result in dismissal from the program of study and/or constitute legal action thereof.

Student Printed Name

Student Signature

Date



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

Purified Protein Derivative (PPD) / Tuberculin Skin Test (TST) or QFT Gold Blood Assay

All information must be complete or it will not be accepted

PPDs must be read within 48-72 hours of administration

PPD	Date & Time Given	Injection Site	Lot # & Manufacturer	Expiration	Result	Induration	Date & Time Read	Initials
Step 1					<input type="checkbox"/> Negative <input type="checkbox"/> Positive	_____mm		
Step 2					<input type="checkbox"/> Negative <input type="checkbox"/> Positive	_____mm		
QFT Gold Blood Assay		QFT Lab Results are required			<input type="checkbox"/> Negative <input type="checkbox"/> Positive			

- Step 1 **and** Step 2 OR the QFT Gold Blood Assay are required.
- Step 2 should be administered 7 - 21 days after Step 1 has been administered.
***There is a max time frame of 21 days between Step 1 and Step 2.**
- Annual 1 Step PPD or a QFT must be completed before the prior results expires.
- If **Positive** PPD – documentation from physician stating any further care is required.
- If PPD result is **POSITIVE** (>10 mm induration), student must provide proof of negative CXR.

Certification: Signature below indicates verification of above initials in administration of PPD/TST.

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division – Student Health Record

Student Name: _____

Student H# _____

INFLUENZA FORM

The seasonal flu vaccine is required for the Fall and Spring semesters. It is not required for the Summer semester. It typically is available every August and will be due in September.

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of, or reporting of, documented result for Influenza Immunization(s).

Healthcare Provider Signature

Title

Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division - Student Health Record

Student Name: _____

Student H#: _____

Tetanus, Diphtheria, Pertussis (TDAP) Form

This form must be complete or an immunization/medical record is needed

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of TDAP immunization and/or titer result.

Healthcare Provider Signature

Title

Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

HEPATITIS B FORM

This form must be complete or an immunization/medical record is needed

	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						
3.						

Or

+ Hepatitis B Titer Result: _____ Date: _____ Initials: _____

Titer result may be reported on this sheet but must be accompanied by lab result with reference range clearly designated.

Or

Declination/Waiver

Certification:

Signature below indicates verification of above initials in administration of Hepatitis B immunization and/or titer result.

Healthcare Provider Signature Title Date

Healthcare Provider Signature Title Date

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

MANDATORY HEPATITIS B VACCINE SERIES IN PROGRESS OR DECLINATION

Instructions:

Check the appropriate box(es) to indicate your compliance with the Hepatitis B requirement.

SERIES IN PROGRESS

- I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all vaccinations as they are completed. Until I am fully vaccinated, I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection.

DECLINATION

- I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the opportunity to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will decide at that time.

Student Signature

H#

Date



Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

MEASLES, MUMPS, RUBELLA (MMR) FORM

IgG TITERS ARE REQUIRED

The actual titer lab results with the scores and reference ranges are required

MEASLES Titer Result: _____ Date: _____ Initials: _____

MUMPS Titer Result: _____ Date: _____ Initials: _____

RUBELLA Titer Result: _____ Date: _____ Initials: _____

- If you previously completed the 2-dose vaccine and any of your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.
- If you did not previously complete the 2-dose vaccine and your current titers are **NEGATIVE** or **EQUIVOCAL**, you are required to receive the following immunizations:
 - If Measles and/or Mumps are **NEGATIVE** or **EQUIVOCAL**: Two (2) doses of MMR are required.
 - If Rubella is **NEGATIVE** or **EQUIVOCAL**: One (1) dose of MMR is required.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						

Certification:

Signature below indicates verification of above initials in administration of MMR immunization and/or titer result.

Healthcare Provider Signature Title Date

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

VARICELLA (CHICKENPOX) FORM

IgG TITERS ARE REQUIRED

The actual titer lab results with the score and reference range are required

VARICELLA Titer Result: _____ Date: _____ Initials: _____

- If you previously completed the 2-dose vaccine and your current titers is **NEGATIVE** or **EQUIVOCAL**, you are required to receive a 1-dose booster vaccine immediately. Documentation for the initial 2-dose vaccine and negative titers results must also be remitted.
- If you did not previously complete the 2-dose vaccine and your current titers is **NEGATIVE** or **EQUIVOCAL**, you are required to receive the 2-dose vaccine beginning immediately.
- Physician documented history of Varicella will not be accepted as proof of immunity.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials
1.						
2.						

Certification:

Signature below indicates verification of above initials in administration of Varicella immunization and/or titer result.

Healthcare Provider Signature Title Date

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



PROFESSIONAL LIABILITY INSURANCE

Required for the following Nursing and Health Science Programs

Computerized Axial Tomography	Phlebotomy (AHS 167)
Dental Assistant (DAT)	Physical Therapy Assistant (PTH)
Dental Hygienist (DHG)	Practical Nursing (LPN/PNR)
Diagnostic Medical Sonography	Radiology Technology
Medical Lab Technology	Registered Nurse (NUR/ADN)
Occupational Therapy Assistant	Respiratory Care
Paramedic	Surgical Technology
Patient Care Medical Technician (AHS 163)	Vascular Sonography

If you change programs, your specialty must be changed on your policy.

Example, if you are a Phlebotomy student during the spring semester and then go into the Radiology program for the summer semester, your policy must be changed from Phlebotomist to Radiology Technologist.

Students may choose a vendor of their choice; however, coverage amounts must be as stated as below.

One 3rd party vendor is Healthcare Providers Service Organization (HPSO)

www.hpso.com – 1-800-982-9491

On the HPSO website, click “Get a Quote” > Select “Students” and “Get Started” > Follow the prompts as a “Student”

Minimum Coverage: \$1,000,000 each claim and \$3,000,000 aggregate

You will receive an email confirming your application was submitted.

Within 24-48 hours, you will receive an email containing your actual Policy.

We will need the **Certificate of Liability** for proof, not a copy of the application or proof of payment.

As of 09/29/2022, the Annual Premium was \$44.10. Prices are subject to change.



Clinical Forms & Disclosures

Click on your program below to access the required clinical forms and disclosures.

Be sure to enter your full name and use your @hgtc.edu email account only.

The system will automatically send us a copy of your completed forms.

You do not need to email us stating they are complete.

You will have the option to download or print the completed forms for your records.

****When entering your birthdate on the forms, you may manually enter your DOB by entering MM/DD/YEAR or you may click on the year to select your birth year, then the month and day.**

[Diagnostic Medical Sonography / Vascular Sonography](#)

[Health Care Certificate / Patient Care Medical Assistant](#)

[Medical Laboratory Technology](#)

[Nursing ADN & PN](#)

[Occupational Therapy Assistant](#)

[Paramedic](#)

[Phlebotomy](#)

[Physical Therapist Assistant](#)

[Radiologic Technology / Computerized Axial Tomography](#)

[Respiratory Care](#)

[Surgical Technology](#)

If you experience any issues while completing the forms,
please contact us at hgtc-clinical@hgtc.edu.



**Immunization Cost Estimates for Students
WITHOUT Health Insurance Coverage**

Some of these ARE covered under most health insurance plans

DISCLAIMER: This information is to be used as a guide only, as it is subject to change. HGTC cannot be held responsible for the prices listed below. It is the student's responsibility to call and confirm availability, pricing, and insurance requirements. HGTC is not affiliated with any of these providers regarding provision of healthcare services and is unable to recommend any specific provider.

You do not have to use these providers. YOU MAY USE YOUR OWN PROVIDER.

The prices below are from March 2023. They are subject to change. Call ahead for pricing.

Immunization	Care Now 843-626-2273 (7 Locations)	Carolina Health Pharmacy 843-215-8200	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	South Strand Internist and Urgent Care 843-945-3030	Little River Medical Center 843-663-8000 Call far ahead for appointments	Palmetto Express Clinic 843-750-0324	Southern Urgent Care 843-357-4357
Office Visit Fee	\$50 + Cost of Services Below	NA	NA	\$150.00	\$95 - \$171	Sliding Scale	\$65.00	\$130.00
Vaccine Admin. Fee	\$52.00	NA	NA	NA	\$17.50	Sliding Scale	NA	\$50.00
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	\$23.00 (PPD) \$120.00 (QFT)	NA	\$74.00	\$34.00 \$60.00 (QFT)	\$50.00 \$112.00 (QFT)	Sliding Scale	\$25.00 (PPD) \$100 (QFT)	\$45.00 (PPD) \$110.00 (QFT)
Chest X-Ray with Positive PPD	\$56.00	NA	NA	\$90.00	\$31.20 - \$98.80	Sliding Scale	NA	\$100.00
MMR Titer	\$109.00	NA	\$99 - \$139	\$280.00	NA	Sliding Scale	\$60.00	\$50.00
Varicella Titer	\$35.00	NA	\$99 - \$139	\$85.00	NA	Sliding Scale	\$30.00	\$50.00
Hep B Titer	\$41.00	NA	\$99 - \$139	\$100.00	NA	Sliding Scale	\$30.00	\$30.00
MMR Vaccine x 1	\$115.00	NA	\$135.00	\$100.00	\$100.00	Sliding Scale	NA	NA
Hep B Vaccine x 1	\$25.00	\$92.00	\$145.00	\$104 (each) (Dynavax) \$156 (2-dose)	\$58.00	Sliding Scale	NA	NA
Varicella Vaccine x1	NA	NA	\$166.00	\$85.00	\$172.00	Sliding Scale	NA	NA
TDAP (Adacel) Vaccine	\$60.00	\$64.00	\$95.00	\$71.00	\$45.00	Sliding Scale	NA	\$75.00
Flu	\$20.00	\$35.00	\$50.00	\$40.00	\$19 - \$26	Sliding Scale	NA	NA

For students who meet certain income guidelines, some services are provided at low or no cost through **the SC Health Departments**. Call (855) 472-3432 to make an appointment at any of these locations.

- Myrtle Beach Health Dept, 21st Ave, Myrtle Beach (843) 448-8407
- Conway Health Dept., Industrial Park Road, Conway (843) 915-8800
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River (843) 915-5654
- Georgetown County Public Health Department, Lafayette Cir, Georgetown (843) 546-5593



Health Science Division - Student Health Record

Student Name: _____

Student H#: _____

CHEST X-RAY FORM

Required ONLY with Positive Tuberculosis Test

CXR Date: _____ Result: _____ Initials: _____

NOTE: Copy of actual result must be attached. CXR result is valid for two (2) years.

If CXR is **NEGATIVE**, student must complete a SYMPTOM ASSESSMENT FORM

If CXR is **POSITIVE**, student will be referred to DHEC for treatment (if applicable) according to DHEC guidelines. Clearance from primary care provider is required for return to clinical setting if student was referred for positive CXR.

Certification:

Signature below indicates verification of above initials in administration of/and reporting result of CXR.

Healthcare Provider Signature

Title

Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.



Health Science Division – Student Health Record

Student Name: _____

Student H#: _____

SYMPTOM ASSESSMENT FORM

(Required Yearly)

Instructions:

Complete this form **ONLY** if you had a Positive (+) Tuberculin Skin Test with a Negative (-) CXR.

Date: _____ Date of Positive PPD: _____ Date of Negative CXR: _____

Have you been treated with tuberculosis medication? Yes No

Have you ever received a BCG (tuberculosis vaccine)? Yes No

Have you been exposed to an isolated case of TB this year? Yes No

Do you have any of the following?

- Productive cough (≥ 3 weeks) Yes No
- Persistent weight loss without dieting Yes No
- Persistent low-grade fever Yes No
- Night sweats Yes No
- Loss of appetite Yes No
- Swollen glands in the neck Yes No
- Recurrent kidney or bladder infections Yes No
- Coughing up blood Yes No
- Shortness of breath Yes No
- Chest pain Yes No

If you answered "YES" to any of the above questions, please explain:

(Note: Clearance from a primary care provider, which may include repeat CXR, is required prior to clinical attendance if you answered "YES" to any of the above questions).

Student's Signature: _____

Date: _____

COVID MEDICAL EXEMPTION FORMS

**PLEASE COMPLETE THE MEDICAL EXEMPTION FORMS FOR
EACH FACILITY**

*Please note the COVID requirement is not mandated by
Horry-Georgetown Technical College.
It is a requirement set forth by the clinical affiliates
in order to attend clinical(s).*

**Upload all forms into the Castle Branch Compliance Tracker
under the COVID requirement.**

Medical Exemption Request

Covid-19 Vaccination – States outside of California

Colleague Information – To be completed by employee

Printed Name:

3-4 ID:

Date:

Date of Birth:

If you wish to request a medical exemption from mandatory vaccination, please sign the attestation below:

I have a medical condition or disability that prevents me from taking any of the COVID-19 vaccines authorized by the FDA. To be eligible for this exemption, I understand that I must provide to my employer (or to the facility where I volunteer or otherwise work) a written statement signed by my licensed healthcare provider, that I qualify for the exemption and indicating the probable duration of my inability to receive the vaccine (or indicating that the duration is unknown).

Employee Signature: _____ Date: _____

Please note, as a part of the exemption quality process, there may be follow-up review of this exemption. You will receive an email notifying you of approval/declination of your request. If you have questions regarding your request, reach out to your human resources representative. If this request is approved, you will be required to practice universal masking in the workplace unless actively eating or drinking. Please follow local or state and/or facility guidance for testing as part of this exemption. If your request is denied, you will either need to receive the COVID-19 vaccination or employment will be terminated.

Healthcare Provider Information – To be completed by healthcare provider

Printed Name:

Provider Specialty:

NPI:

Phone Number:

Licensed Healthcare Provider: Please mark the contraindications / precautions or other medical condition / disability that apply to this patient and sign and date this form. Licensed Healthcare Provider must include either a treating physician (M.D. or D.O.) or treating advanced practice professional (nurse practitioner or physician assistant). **Note: Health Care Providers cannot sign their own exemption / certification request.**

**Vaccine Contraindication Certification (list all that apply) –
Requires healthcare provider signature**

Note – Contraindication to one vaccine does not preclude receipt of another vaccine type

<p>Johnson & Johnson</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction <input type="checkbox"/> Previous history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> History of Guillain-Barre Syndrome post-vaccine <input type="checkbox"/> Contraindication to mRNA vaccines (must specify below) AND female under age of 50 <input type="checkbox"/> My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). <p>Additional Information:</p>
<p>mRNA Pfizer or Moderna</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Known history of severe allergic reaction (anaphylaxis) to any component of the vaccine or immediate allergic reaction <input type="checkbox"/> Known history of severe reaction (anaphylaxis) to the first dose of either mRNA vaccine <input type="checkbox"/> Previous history of Multisystem Inflammatory Syndrome (MIS) of adults or children <input type="checkbox"/> Documented Myocarditis after first dose of mRNA vaccine <input type="checkbox"/> My patient has a physical or mental impairment that substantially limits one or more major life activities and prevents the patient from safely receiving the vaccine. (More detail regarding the medical condition and how it prevents the patient from receiving the vaccine must be attached). <p>Additional information:</p>

Deferral Certification – Requires healthcare provider signature

<p>General (Request for Deferral)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Acute COVID-19 infection documented in the past 90 days <input type="checkbox"/> Receipt of monoclonal/polyclonal COVID-19 antibody treatment within the past 90 days <input type="checkbox"/> Receipt of high titer COVID-19 antibody treatment (Convalescent Plasma) within the past 90 days <p><i>*Deferral timeframe needed from provider for when employee can receive vaccination.*</i> Date employee can be vaccinated:</p> <p>Additional information:</p>
---------------------------------------	--

I attest that I have a healthcare provider-patient relationship with the employee identified above and that the above statements are true and accurate.

Healthcare Provider Signature: _____ **Date:** _____

For internal use only:
(Post-initial review)

This form is:

- Complete**
- Incomplete**

Internal review date (if applicable):

Comments:

McLeod Health

The Choice for Medical Excellence

McLeod Health Request for Medical Exemption from COVID Vaccine (2021)

Please print information below:

Employee Name: _____ Date of Birth _____ Employee ID# _____

Employee e-mail: _____ Employee Cell# _____

Department: _____ Director/Manager: _____

Healthcare Provider Name: _____ Provider Phone #: _____

To be completed by Healthcare Provider:

Pursuant to a federal mandate issued by the federal government for providers of healthcare, McLeod Health employees must be fully vaccinated against COVID-19. The individual named above is seeking a medical exception to the requirement for COVID-19 vaccination or a delay because of a temporary condition or medical circumstance. Please complete this form to assist McLeod Health in its reasonable accommodation process. If you have questions completing this form, please contact McLeod Employee/Occupational Health Services at 843-777-5146.

Please provide at least the following information, where applicable:

1. The applicable contraindication or precaution for COVID-19 vaccination, and for each contraindication or precaution indicate: (a) whether it recognized by the CDC pursuant to its guidance; and (b) whether it is listed in the package insert or Emergency Use Authorization fact sheet for each of the COVID-19 vaccines authorized for use in the United States;
2. A statement that the individual's condition and medical circumstances relating to the individual are such that COVID-19 vaccination is not considered safe, indicating the specific nature of the medical condition or circumstances that contraindicate immunization with a COVID-19 vaccine or might increase the risk for a serious adverse reaction; and

Description the medical condition for which the employee listed above should be exempted from complying with a COVID-19 vaccination requirement:

The condition described above is: Permanent Temporary – expected date to end or expire _____
(allowing for COVID-19 vaccination to begin after the date provided)

3. Any other medical condition that would limit the employee from receiving any COVID-19 vaccine

Employee's Healthcare Provider Signature and Title: _____ Date: _____

Provider License Number: _____

McLeod Health

The Choice for Medical Excellence

McLeod Health Request for Medical Exemption from COVID Vaccine 2021

(Page 2 to be completed by Employee and Employee Health)

To be Completed by Employee:

Are you requesting an accommodation? _____ Yes _____ No

What accommodation are you requesting? _____

Please note that if your exemption request is approved, you may be required by your employer or other responsible party to take additional steps to protect you and others from contracting and spreading COVID-19 or other diseases. Workplaces are not required to provide this accommodation if doing so would pose a direct threat to patients, the excepted individual or others in the workplace or would create an undue hardship.

Employee Signature: _____ Date: _____

Below to be completed by Employee Health:

Medical Exception Approved on: _____ Permanent Temporary – Expiration date : _____

Describe the approved accommodation: _____

Dates of accommodation: From: _____ To: _____

Employee Health Representative Approving Signature: _____ Date: _____

Medical Exemption from COVID-19 Vaccine Requirement Request Form

Part I. Employee Section: Complete the following information

Name (last, first): _____ Employee ID Number: _____

Work Email Address: _____ Phone Number: _____

After you and your provider complete this form, upload it to the MUSC Vaccine Tracker at (<https://www.musc.edu/medcenter/covid-19/vaccine/policy.html>). This form and any received supporting information will be kept in your employee health record. After review of the information, and upon its acceptance, your compliance record will be updated to reflect your policy compliance status.

Part II. Provider Section: A licensed physician, PA, or NP must complete Section II and sign attesting to their medical opinion below. Forms that have Part II completed by the employee will **NOT** be accepted.

Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the below identified medical contraindication precludes the individual from receiving any/all vaccinations for COVID-19.

Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>.

The following are **NOT considered contraindications to COVID-19 vaccination:**

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre Syndrome
- Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
- Breastfeeding
- Immunosuppressed person in the employee's household
- Alpha-gal Syndrome
- **The COVID vaccines do not contain Egg or gelatin, allergies to these substances are not contraindication**

If a contraindication is applicable, please select the applicable medically indicated contraindication below:

Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG) (Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG)

Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine (Please describe response in detail below and contraindication to alternative vaccines.)

Natural immunity attained through prior infection. As long as our epidemiological monitoring of natural immunity vs. vaccine immunity shows these to be equivalent, natural immunity may count as a valid medical exemption and may be evaluated periodically (Be specific, please provide dates and describe in detail below)

Other medical circumstance/condition making vaccination unsafe with any available COVID-19 vaccine (Be specific & describe in detail below, and state whether the medical circumstance/condition is temporary or long term)

Signature of Healthcare Provider: _____ Date: _____

Printed name: _____ Practice name: _____

Practice telephone number: _____ Practice email: _____



REQUEST FOR A MEDICAL EXCEPTION

As part of our “Safe in Our Care” commitment, all Tidelands Health employee, provider, volunteer, learner and contract partners are required to receive the COVID-19 vaccination, with exceptions only as required by law. Team members may seek a legal exception to the vaccination requirement due to a CDC-recognized clinical contraindication or precaution to COVID-19 vaccination by submitting this form. Tidelands Health may also ask for other information, as needed.

You MUST submit this form, along with a signed medical certification form from a licensed medical provider involved in your care, to request a medical exception. Per CMS Medicare Conditions of Participation, this form supersedes and replaces any previous COVID-19 vaccine declination form.

Per CMS Medicare Conditions of Participation, previous COVID-19 infection (natural immunity) is not a valid reason for a medical exception.

Requests for “medical accommodation” or “medical exception” will be treated as requests for a disability accommodation and evaluated and decided under applicable Rehabilitation Act standards for reasonable accommodation absent undue hardship to Tidelands Health. Tidelands Health will be required to keep confidential any medical information provided, subject to the applicable Rehabilitation Act standards. Team members who receive an exception from the vaccination requirement will instead comply with alternative health and safety protocols.

Submitting this form constitutes a declaration that the information you provide is, to the best of your knowledge and ability, true and correct. Any intentional misrepresentation may result in disciplinary action, up to and including termination.

First name: _____

Last name: _____

Employee ID number: _____ Social security number: _____ - _____ - _____

CDC-recognized contraindication to COVID-19 vaccination:

- Severe allergic reaction after a previous dose
- Diagnosed allergy to COVID-19 vaccine component
- Multi-System Inflammatory Syndrome

I am requesting a medical exception to the requirement for COVID-19 vaccination. I declare that the information I have provided is true and correct to the best of my knowledge and ability.

To be considered for a medical exception, you must submit a medical certification form completed by a licensed medical provider involved in your care. Once your provider has completed the form, please provide the form to Employee Health.

I declare to the best of my knowledge and ability that the foregoing is true and correct.

_____/_____/_____
Full name Signature Date



CMC
CONWAY MEDICAL CENTER

EH-4546-FRM
REV 2 3.6.23

Request for Medical Exemption from COVID-19 Vaccine Requirement

Employee Section: Complete the following information

Name (last, first) _____ CMC Badge # _____

Email Address: _____ Best Phone Number: _____

After you and your provider complete this form, scan it and submit it to _____. Information will be kept only in your confidential Employee Health record. After review and acceptance of this information, your OESO compliance record will be updated within one week.

Provider Section: A licensed physician, PA, or NP must complete and sign this section. Forms completed by the employee will not be accepted.

Physician/Provider Instructions: By completing this form, you certify that different methods of vaccinating against COVID-19 have been considered, and that the following medical contraindication precludes any/all vaccinations for COVID-19.

Guidance for medical exemptions for COVID-19 vaccination can be obtained from the Advisory Committee on Immunization Practices (ACIP) available at <https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html>.

The following are NOT considered contraindications to COVID-19 vaccination:

- Local injection site reactions after (days to weeks) previous COVID-19 vaccines (erythema, induration, pruritus, pain, etc.)
- Expected systemic vaccine side effects in previous COVID-19 vaccines (fever, chills, fatigue, headache, lymphadenopathy, vomiting, diarrhea, myalgia, arthralgia)
- Vasovagal reaction after receiving a dose of any vaccination
- Being an immunocompromised individual or receiving immunosuppressive medications
- Autoimmune conditions, including Guillain-Barre Syndrome
- Allergic reactions to anything not contained in the COVID-19 vaccines, including injectable therapies, food, pets, venom, environmental allergens, oral medication, latex, etc.
- Breastfeeding
- Immunosuppressed person in the employee's household
- Alpha-gal Syndrome
- **The COVID vaccines do not contain Egg or gelatin, therefore allergies to these substances are not contraindications.**

Please select medically indicated contraindication below:

- Severe allergic reaction (anaphylaxis) after a previous dose of or to a component of the COVID-19 Vaccine, including Polyethylene Glycol (PEG) (Please describe response in detail below and contraindication to alternatives, such as the Johnson & Johnson vaccine, which does not contain PEG)
- Immediate allergic reaction to a previous dose or known (diagnosed) allergy to a component of the vaccine (Please describe response in detail below and contraindication to alternative vaccines.)
- Other medical circumstance preventing vaccination with any available COVID-19 vaccine (Be specific & describe in detail below)
- Janssen/J&J vaccine contraindication _____
- Pfizer-BioNtech vaccine contraindication _____
- Moderna vaccine contraindication _____
- Novavax vaccine contraindication _____

Signature of Healthcare Provider: _____ Date: _____

Practice telephone number: _____ Practice email: _____

COVID RELIGIOUS EXEMPTION FORMS

**PLEASE COMPLETE THE RELIGIOUS EXEMPTION FORMS FOR
EACH FACILITY**

*Please note the COVID requirement is not mandated by
Horry-Georgetown Technical College.
It is a requirement set forth by the clinical affiliates
in order to attend clinical(s).*

**Upload all forms into the Castle Branch Compliance Tracker
under the COVID requirement.**

Religious Exemption Request

Covid-19 Vaccination – States outside California

Colleague Name

Colleague 3-4 ID

Date

Date of Birth

A religious exemption to COVID-19 immunization may be granted based on an individual's sincerely held religious belief, practice or observance that prohibits COVID-19 vaccination. A "religious belief, practice, or observance" includes moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views. Social, political, or economic philosophies, as well as personal preferences, do not constitute sincerely held religious beliefs.

- I attest that my religious belief is sincerely held and receiving the COVID-19 vaccination conflicts with my religious belief.

Identify in the box below, your sincerely held religious belief. You may attach any documents that support your statement:

Explain how this religious belief prevents you from receiving the COVID-19 vaccination.

By signing this document, I attest that my statement above is true and accurate and that I hold a sincere religious belief that prohibits COVID-19 vaccination.

Colleague Signature: _____ Date: _____

Please note, as a part of the exemption quality process, there may be follow-up review of this exemption. If this request is approved, you will be required to practice universal masking in the

workplace unless actively eating or drinking. Please follow local or state and/or facility guidance for testing as part of this exemption. If your request is denied, you will either need to receive the COVID-19 vaccination or employment will be terminated.

For internal use only:

(Post-Initial Review)

This form is:

- Complete**
- Incomplete**

Internal review date (if applicable):

Comments:

McLeod Health

The Choice for Medical Excellence

McLeod Health Request for Religious Exemption from COVID Vaccine (2021)

Please print information below:

Employee Name: _____ Date of Birth _____ Employee ID# _____

Employee e-mail: _____ Employee Cell# _____

Department: _____ Director/Manager: _____

Religion: _____

How long have you practiced this religion? _____

Please describe your religious/faith belief and how it affects your ability to receive the COVID vaccine:

Please describe common examples of your practice of this religion in other aspects of your life:

Are you requesting an accommodation? _____ Yes _____ No

What accommodation are you requesting? _____

Please note that if your exception request is approved, you may be required by your employer or other responsible party to take additional steps to protect you and others from contracting and spreading COVID-19 or other diseases. Workplaces are not required to provide this accommodation if doing so would pose a direct threat to patients, the excepted individual or others in the workplace or would create an undue hardship.

The above information is true and accurate. I understand that I can change my mind at any time and accept the vaccination if it is still available.

Employee Signature: _____ Date: _____

Below to be completed by Human Resources:

Describe the approved accommodation: _____

Dates of accommodation: From: _____ To: _____

HR Rep Signature: _____ Date _____

Please return form to Human Resources or email to Human.Resources@mcleodhealth.org or call 843-777-2595

COVID Religious Declination

Description of your religious beliefs that are contrary to the Covid-19 vaccine?

Please describe the nature of your objection to the Covid-19 vaccine requirement.

Would complying with the COVID-19 vaccination requirement substantially burden your religious exercise? If so, please explain how:

How long have you held the religious belief underlying your objection?

Please describe whether, as an adult, you have received any vaccines against any other diseases (such as flu vaccine or a tetanus vaccine) and, if so, what vaccine you most recently received and when, to the best of your recollection:

If you do not have a religious objection to the use of all vaccines, please explain why your objection is limited to particular vaccines:

If there are any other medicines or products that you do not use because of the religious belief underlying your objection, please identify them:

Please provide any additional information that you think may be helpful in reviewing your request:



REQUEST FOR A RELIGIOUS EXCEPTION

As part of our “Safe in Our Care” commitment, all Tidelands Health employee, provider, volunteer, learner and contract partners are required to receive the COVID-19 vaccination, with exceptions only as required by law. In certain circumstances, federal law may entitle a team member who has a religious objection to the COVID-19 vaccination requirement to an exception from that requirement, in which case the team member would instead comply with alternative health and safety protocols. Tidelands Health is committed to respecting the important legal protections for religious liberty.

To request a religious exception, please fill out and submit this form. You **MUST** submit this form to request a religious exception. Per CMS Medicare Conditions of Participation, this form supersedes and replaces any previous COVID-19 vaccine declination form.

The purpose of this form is to start the accommodation process and help determine whether you may be eligible for a religious exception. We encourage you to provide as much information as possible to enable Tidelands Health to evaluate your request, and we may ask you for additional information as needed to determine if you are legally entitled to an exception. Objections to COVID-19 vaccinations that are based on non-religious reasons, including personal preferences or non-religious concerns about the vaccine, do not qualify for a religious exception.

An individual’s beliefs—or degree of adherence—may change over time and, therefore, a team member’s newly adopted or inconsistently observed practices may be based on a sincerely held religious belief. All requests for a religious exception will be evaluated on an individual basis.

Submitting this form constitutes a declaration that the information you provide is, to the best of your knowledge and ability, true and correct. Any intentional misrepresentation may result in disciplinary action, up to and including termination.

First name: _____ Last name: _____

Employee ID number: _____ Social security number: _____ - _____ - _____

Please describe the nature of your objection to the COVID-19 vaccination requirement. _____

Would complying with the COVID-19 vaccination requirement conflict with your sincerely held religious beliefs, practices or observances? If so, please explain how. _____



Application for Religious Exemption of COVID-19 Vaccine

EH-652-FRM
REV 1 05.23.22

All information requested must be provided and all questions must be answered in order for your application to be considered. Information will be kept confidential. If your application is approved, it will be recorded in your compliance record within one week.

Name:

CMC Badge ID:

Job Title:

Work Area:

Best Phone Number:

Supervisor:

CMC Email Address:

Section A:

Do you provide direct patient care?

- Yes
 No

Do you work in an area where patient care is provided (example: inpatient unit or clinic)?

- Yes
 No

Do you have patient or visitor contact (example: registering, providing directions, praying)?

- Yes
 No

Do you provide a service to patients or visitors (example: food preparation, financial counseling, music therapy)?

- Yes
 No

Do you understand that you will be required to wear a mask while indoors in CMC owned or leased buildings and may be tested weekly for COVID-19?

- Yes
 No

Do you understand that you may be asked to submit an application for religious exemption in the future if vaccination or a booster is recommended more regularly (having been approved for an exemption does not automatically mean your exemption will be approved permanently)?

Yes

No

Section B: Description of your religious beliefs that are contrary to the COVID-19 vaccine

Section C:

The information I am providing in completing this form accurately reflects my sincerely held religious beliefs.

Signature: _____

Date: _____

Submit this completed form to Kim Nathan by email to kimberly.nathan@cmc-sc.com.