

STUDENT NAME: \_\_\_\_\_  
Last First MI

ADDRESS: \_\_\_\_\_  
                     Street                    City                    State                    Zip Code

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_

Name	Phone
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**It is the student's responsibility to maintain copies of all documents submitted with applications.** The Health Sciences Department *does not* make copies for students or provide copies of documents submitted. All Health documents are shredded after the student completes the program or is no longer in attendance.

Santa Rosa Junior College Health Science program is interested in the health and welfare of all its students and patients that students may care for. Students must meet the health requirements of the program and the clinical settings where students are sent to practice (with or without reasonable accommodation). Please provide your evaluation of this student's current health status. **(Health evaluation/physical assessment must be completed within the last year by an MD, NP, or PA.)**

1501 Mendocino Avenue, Santa Rosa, CA 95401-4395 \* (707) 527-4271 \* Fax (707) 521-6916  
Sonoma County Junior College District \* [www.santarosa.edu](http://www.santarosa.edu)

## *Santa Rosa Junior College Health Sciences Department*

### **TECHNICAL STANDARDS**

The Radiologic Technology curriculum requires students to engage in diverse, complex, and specific experiences essential to the acquisition and practice of essential healthcare skills and functions. Unique combinations of cognitive, affective, psychomotor, physical, and social abilities are required to satisfactorily perform these functions. In addition to being essential to the successful completion of the requirements of the Radiologic Technology program, these skills are necessary to ensure the health and safety of patients, fellow candidates, faculty and other healthcare providers.

Below is a list of some of the technical standards required in the Radiologic Technology Program. These are examples of learning activities that students will be required to participate in during the program and not meant to be an exhaustive list of all technical standards.

### **Necessary Skills**


Students must be able to perform the essential functions of a radiologic technologist in any facility/department in which they are attending clinical training. These functions include:

- Ability to distinguish colors
- Ability to see within 20 inches or as far as 20 feet (corrective lenses acceptable).
- Accurately document patient care on paper and/or in the electronic health record in a timely manner.
- Adapt to unexpected changes and stressful situations.
- Assemble and transport a wide range of equipment and supplies to and from patient rooms and other clinical care areas.
- Assist patients with mobility, which may include turning, sitting up, moving patients in and out of beds, gurneys, chairs and x-ray examination tables.
- Communicate with patients, caregivers, family members, and other healthcare personnel in a manner that is clear, articulate, accurate, and ensures that the plan of care is understood.
- Empathize with the feelings and situations of others.
- Hand/finger dexterity to accomplish duties requiring repetitive motions/actions such as manipulating radiographic and medical equipment and accessories by reaching, pulling, extending, flipping switches, rotating knobs and activating buttons.
- Kneeling/crouching for extended periods of time.
- Perform emergency care in a safe and timely manner including the initiation of life saving interventions such as CPR when indicated.
- Possess adequate sense of hearing (i.e/ ability to hear alarms, patients/patients' families, instructions from physicians/department staff, etc.)
- Provide physical and emotional support to the patients during radiographic procedures.
- Pushing/pulling (i.e. wheelchairs, gurneys, medical equipment)
- Reaching with both arms: up, down, side to side
- Safely work in all levels of hospital or radiology department lighting that varies from low levels of illumination to bright light levels.
- Sitting for extended periods of time.
- Standing for extended periods of time.
- Tolerate strong, unpleasant odors.
- Walking (to and from patient areas, assisting patients to walk, etc.)
- Wear a N-95 respirator when interacting with a patient in respiratory precautions.
- Work and move safely in tight spaces already crowded with other patient care apparatus.

**STUDENTS:** Complete this section, share with medical provider, and return original to Program Director with the completed Health Evaluation.

**N-95 medical clearance**

**Part A. Section 2.** Questions 1 through 14 below must be answered by every student. Please check YES or NO.

1. Today's date: \_\_\_\_\_ Your student ID number: \_\_\_\_\_
2. If you do not have a student ID number please provide last 4 digits of SS# \_\_\_\_\_
3. This student is supervised by: Christine McLarty, MS-RIS, RT(R)(CT), ARRT, CRT Program Director
4. Your name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_
5. Your age (to nearest year): \_\_\_\_\_ DOB \_\_\_\_\_
6. Sex : (check one) ☐ MALE ☐ FEMALE
7. Your height: \_\_\_\_\_ ft, \_\_\_\_\_ in
8. Your weight: \_\_\_\_\_ lbs.
9. Your job title: Radiologic Technology Student Intern
10. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_
11. The best time to phone you at this number: \_\_\_\_\_
12. Has the program director told you how to contact the health care professional who will review this questionnaire (check one)? Yes ☐ No ? ☐
13. Check the type of respirator you will use (you can check more than one category):  
 N, R, or P disposable respirator (filter-mask, non-cartridge type only).
14. Have you worn a respirator (check one)? Yes ☐ No ? ☐ If YES, what type(s):  
\_\_\_\_\_

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**Part A. Section 2.** Questions 1 through 14 below must be answered by every student who has been selected to use any type of respirator. Please check YES or NO.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No ? ☐
2. Have you ever had any of the following conditions?
  - a. Seizures (fits)? Yes ☐ No ? ☐
  - b. Diabetes (Sugar disease)? Yes ☐ No ? ☐
  - c. Allergic reactions that interfere with your breathing? Yes ☐ No ? ☐
  - d. Claustrophobia (fear of closed-in places)? Yes ☐ No ? ☐
  - e. Trouble smelling odors? Yes ☐ No ? ☐
  - f. High cholesterol? Yes ☐ No ? ☐

3. Have you ever had any of the following pulmonary or lung problems?

- a. Asbestosis? Yes ☐ No ? ☐
- b. Asthma? Yes ☐ No ? ☐
- c. Chronic bronchitis? Yes ☐ No ? ☐
- d. Emphysema? Yes ☐ No ? ☐
- e. Pneumonia? Yes ☐ No ? ☐
  - i) How long ago did you have pneumonia? \_\_\_\_\_
  - ii) Has the pneumonia completely resolved? Yes ☐ No ? ☐
- f. Tuberculosis? Yes ☐ No ? ☐
- g. Silicosis? Yes ☐ No ? ☐
- h. Pneumothorax (collapsed lung)? Yes ☐ No ? ☐
- i. Lung cancer? Yes ☐ No ? ☐
- j. Broken ribs? Yes ☐ No ? ☐
  - i) How many ribs did you break? \_\_\_\_\_
  - ii) Do you currently have any rib pain? Yes ☐ No ? ☐
  - iii) Did your rib fracture result in any shortness of breath? Yes ☐ No ? ☐
- k. Any chest injuries or surgeries? Yes ☐ No ? ☐
- l. Any other lung problem that you've been told about? Yes ☐ No ? ☐
  - i) Describe \_\_\_\_\_

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

- a. Shortness of breath? Yes ☐ No ? ☐
- b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? Yes ☐ No ? ☐
- c. Shortness of breath when walking with other people at an ordinary pace on level ground? Yes ☐ No ? ☐
- d. Have to stop for breath when walking at your own pace on level ground? Yes ☐ No ? ☐
- e. Shortness of breath when washing or dressing yourself? Yes ☐ No ? ☐
- f. Shortness of breath that interferes with your job? Yes ☐ No ? ☐
- g. Coughing that produces phlegm (thick sputum)? Yes ☐ No ? ☐
- h. Coughing that wakes you early in the morning? Yes ☐ No ? ☐
- i. Coughing that occurs mostly when you are lying down? Yes ☐ No ? ☐
- j. Coughing up blood in the last month? Yes ☐ No ? ☐
- k. Wheezing? Yes ☐ No ? ☐

- l. Wheezing that interferes with your job? Yes ☐ No ? ☐
- m. Chest pain when you breathe deeply? Yes ☐ No ? ☐
- n. Any other symptoms that you think may be related to lung problems? Yes ☐ No ? ☐
5. Have you ever had any of the following cardiovascular or heart problems?
- a. Heart attack? Yes ☐ No ? ☐
- b. Stroke? Yes ☐ No ? ☐
- c. Angina? Yes ☐ No ? ☐
- d. Heart failure? Yes ☐ No ? ☐
- e. Swelling in your legs or feet (not caused by walking) Yes ☐ No ? ☐
- f. Heart arrhythmia (heart beating irregularly)? Yes ☐ No ? ☐
- g. High blood pressure? Yes ☐ No ? ☐
- h. Any other heart problem that you've been told about Yes ☐ No ? ☐
6. Have you ever had any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest? Yes ☐ No ? ☐
- b. Pain or tightness in your chest during physical activity? Yes ☐ No ? ☐
- c. Pain or tightness in your chest that interferes with your job? Yes ☐ No ? ☐
- d. In the past two years, have you noticed your heart skipping / missing beats? Yes ☐ No ? ☐
- e. Heartburn or indigestion that is not related to eating? Yes ☐ No ? ☐
- f. Any other symptoms that you think may be related to heart or circulation problems?  
Yes ☐ No ? ☐
7. Do you currently take medication for any of the following problems?
- a. Breathing or lung problems? Yes ☐ No ? ☐
- b. Heart trouble? Yes ☐ No ? ☐
- c. Blood pressure? Yes ☐ No ? ☐
- d. Seizures (fits)? Yes ☐ No ? ☐
8. If you've used a respirator, have you ever had any of the following problems?  
(If you've **never** used a respirator, check the following space ☐ and go question 9)
- a. Eye irritation? Yes ☐ No ? ☐
- b. Skin allergies or rashes? Yes ☐ No ? ☐
- c. Anxiety or Claustrophobia? Yes ☐ No ? ☐
- d. General weakness or fatigue? Yes ☐ No ? ☐
- e. Any other problem that interferes with your use of a respirator. Yes ☐ No ? ☐
9. How often are you expected to use the respirator(s)

(check YES or NO for all answers that apply to you)?

~~a. Escape only (no rescue):~~

~~b. Emergency rescue only:~~

~~c. Less than 5 hours per week:~~

➡ d. Less than 2 hours per day: Yes ☐ No ? ☐

~~e. 2 to 4 hours per day:~~

~~f. Over 4 hours per day:~~

10. Work requiring respirator use is (check all that apply):

**LIGHT** MODERATE HEAVY

Examples of **light** work are: sitting while writing, performing light assembly work, and controlling machines.

Examples of **moderate** work are: standing while nailing, transferring a moderate load (about 35 lbs.) at trunk level, and walking on a level surface about 2 mph.

Examples of **heavy** work are: lifting a heavy load (about 50 lbs) from the floor to your waist, shoveling, and standing while bricklaying.

11. Do you normally have a beard, goatee, mustache, or other facial hair growth? Yes ☐ No ? ☐

a) Does your facial hair come in contact the seal of the respirator? Yes ☐ No ? ☐

12. How much exercise (outside of work) do you get in a typical week?

Please explain:

13. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ? ☐

*Santa Rosa Junior College Radiologic Technology Program*

REPORT OF PHYSICAL EXAMINATION

**TO THE EXAMINING PHYSICIAN OR HEALTH CARE PROVIDER**

Santa Rosa Junior College Health Science program is interested in the health and welfare of all its students and patients that students may care for. Students must meet the health requirements of the program and the clinical settings where students are sent to practice (with or without reasonable accommodation). Please provide your evaluation of this student's current health status. **(Health evaluation/physical assessment must be completed within the last year by an MD, NP or PA.)**

My signature below indicates that I have performed a complete history and physical examination on \_\_\_\_\_, a student admitted to the Santa Rosa Junior College Radiologic Technology Program In my opinion, this student:

**TECHNICAL STANDARDS – Check one**

- ☐ Meets the physical and mental requirements listed above, or;  
☐ Can meet the physical and mental requirements listed with reasonable accommodation.

**N-95 – Check one**

- ☐ Medically approved for use of all close-fitting respirator equipment other than SCBA for which he/she has been properly fit tested. (Must not have facial hair at mask seal.) Can wear PAPR.  
☐ Not medically approved for use of any respirator equipment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Provider**

Address \_\_\_\_\_

Phone number \_\_\_\_\_

~~~ Office Stamp here ~~~

## REASONABLE ACCOMMODATIONS – TO BE COMPLETED BY STUDENT

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Reasonable accommodations are modifications or adjustments that enable a qualified individual with a disability to perform the technical standards involved in a Health Sciences program. These accommodations may involve modification of the learning environment, changes in the manner or circumstances in which learning activities are performed, and/or changes that enable a qualified individual with a disability to enjoy equal benefits and privileges of participation in a Health Sciences program.

Please indicate below whether you require or do not require any reasonable accommodation[s] connected with any aspect of the program to which you have been admitted.

Based on my review of the *SRJC Health Sciences Health Requirements and Technical Standards* (initial one of the statements below):

- ☐ I can meet the technical standards with reasonable accommodations. I will make an appointment with the SRJC Disabled Student Resource Center for evaluation of accommodation needs while in the Health Sciences program. See guidelines at: <https://drd.santarosa.edu/>
- ☐ I have read the technical standards. To my knowledge, I can meet the technical standards without limitations or need for reasonable accommodation.

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Print Name

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Date

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Signature

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Date

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Description of accommodation if needed:

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## Santa Rosa Junior College Radiologic Technology - Immunization Requirements

*Immunization requirements for health care workers, including students, are different than immunization requirements for the general population. These requirements are set by the program/ clinical facilities where students provide patient care. Pregnant students need to see their health care provider for guidelines for immunizations when pregnant. For more in depth explanations, please refer to: <https://www.cdc.gov/acip/vaccine-recommendations/>*

**Upon acceptance to the Rad Tech Program: Establish an account with Castlebranch, <https://www.castlebranch.com/> The package code for SRJC Radiologic Technology is SG97. Upload copies to your account on Castlebranch verifying the following:**

1. Tdap within the past ten years. Once one Tdap booster is given, subsequent boosters may be Td.
2. Rubella immunization x 2 or positive Rubella serology titer \* Rubeola immunization x2 or positive Rubeola serology titer \* Mumps immunization x2 or positive Mumps serology titer \* (\* *Combined MMR vaccine immunization*)
3. Varicella immunization (two if given as an adult) OR positive Varicella serology titer
4. Hepatitis B Series
  - a) Positive Hepatitis B Surface Antibody titer (lab report required) OR
  - b) Hepatitis B 1<sup>st</sup> vaccine (1<sup>st</sup> month)
  - c) Hepatitis B 2<sup>nd</sup> vaccine (2<sup>nd</sup> month) (required for entry to clinical settings).
  - d) Hepatitis B 3<sup>rd</sup> vaccine (6<sup>th</sup> month)

*If not immune, contact health care provider to have another series of three immunizations. No additional testing is required after the second series of three immunizations.*

5. TB Clearance – pre-program admittance – 3 options

### 2 Step TB Skin Test

- 2-step test according to the following schedule: The 1st PPD test is administered and must be read 48-72 hours after it is placed. If the results of the first step are negative, students will schedule to have a 2nd PPD test within one to three weeks after the 1st test. The 2nd PPD test is administered and needs to be placed and then read 48-72 hours later.

OR Negative QuantiFERON Gold blood test

OR Clear chest x-ray within the past year AND TB Clearance Form

- Only if the skin test or blood test are positive or for students who cannot have a PPD or have a history of a positive PPD they must submit documentation, (radiology report) of a negative chest x-ray and TB Clearance Form within the last year prior to entrance into the Radiologic Technology program. An annual TB Clearance Form must be completed thereafter. Request the TB Clearance Form from Program Director.

6. TB Clearance will need to be repeated annually with a 1-step skin test, QuantiFERON Gold blood test, or chest x-ray and TB Clearance Form.

7. Annual flu (seasonal and H1N1) - Each student is to avail themselves of the vaccine at the SRJC Student Health Center, health care provider, or community flu clinics. Even though it is not flu season when students are admitted, we will require student's documentation to verify completion of this requirement every fall by October 15th. You will need to have the current vaccine annually.
8. COVID - A minimum of two vaccines and one booster is RECOMMENDED. Some of our clinical sites do require the Covid-19 vaccine and booster, but will accept a declination with full-time masking required. All clinical sites reserve the right to change their requirements at the advice of the CDC, state or county.

***Hospital employees are allowed to decline the flu vaccinations or Covid-19 vaccinations with a signed declination statement or exemption. Students however are not employees and clinical settings may decline a student if not fully immunized. Students who are unable to complete their clinical rotations will not meet course objectives and will fail the course.***