



Fall 2026-27

Dear Dental Assisting Applicant,

Welcome to the Dental Assisting Program at Mohave College.

In just one semester, you will complete the program and become eligible to sit for the Dental Assisting National Board (DANB) National Entry Level Dental Assistant (NELDA) exam.

Continuation in this course is contingent upon the completion of all requirements outlined on page 2 under "Next Steps." Failure to meet these requirements will result in removal from the program.

Please read through the entire packet carefully.

Additional requirements include a background check, drug screening, and immunization tracking. Participation in offsite clinicals at local dental facilities requires full compliance with these health and safety standards. All required documentation must be submitted and marked compliant by Monday, October 12, 2026 in order to proceed to the internship.

A mandatory orientation is scheduled for Monday, August 17 at 11:00 am in BHC Building 900, Room 902.

We are pleased to welcome you to the program and look forward to working with you.

Sincerely,

A handwritten signature in black ink that reads "Tracy M. Gift".

Tracy M. Gift EdS, RDH

**MOHAVE COLLEGE**

(District Office)

1971 Jagerson Ave.  
Kingman, AZ 86409

**Bullhead City Campus**

3400 Highway 95  
Bullhead City, AZ 86442

**Lake Havasu City Campus**

1977 Acoma Blvd. West  
Lake Havasu City, AZ 86403

**Neal Campus - Kingman**

1971 Jagerson Ave.  
Kingman, AZ 86409

**Colorado City Campus**

480 S. Central  
Colorado City, AZ 86021

**WWW.MOHAVE.EDU**

**1.866.664.2832**

## Dental Assisting Program Next Steps

1

**Register for classes** - [MyMohave](#) These classes are designed to be completed together in a single semester, please register for all 7 courses in the same term.

DAE 100      DAE 111      DAE 114  
DAE 101      DAE 112      DAE 128  
DAE 105

2

**Complete the Dental Assisting forms (click the links below):**

- [1. Dental Assisting Academic Work Agreement](#)
- [2. Dental Assisting Technical Standards Requirements](#)

3

**Order Uniforms** - See page 3.

4

**Order Textbooks** - See page 4.

5

**Complete the Precheck and SentryMD** - see page 5 & 6 of this packet. The deadline for this documentation is Monday, October 12, 2026. This portion will cover background check, drug screening, and immunization as well as the health documentation requirements.

**STUDENTS ARE REQUIRED TO WEAR APPROPRIATE PROGRAM APPROVED UNIFORMS:  
AT ALL TIMES IN THE DENTAL CLINIC**

## UNIFORM ITEMS



**Scrub Top** - Black V-neck scrub with white Dental Assisting logo embroidery on the left chest.



**Scrub Pants** - Black scrub pants, including cargo pants or joggers.



**Shoes** - Solid surface, closed toe & closed heel, any color or design.  
*\*No porous or canvas material shoes.*



**Scrub Jacket** - Black lab coat with white Dental Assisting logo embroidery on the left chest.

## APPROVED UNIFORM LOGO



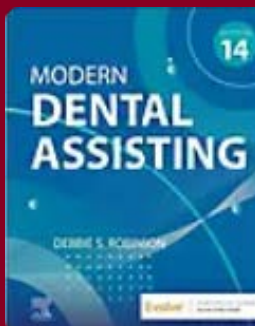
The approved **logo must be embroidered on ALL tops** worn as part of the uniform, including the scrub jacket if purchased.

**PLACEMENT:** Left chest

**SIZE:** approx. 3" to 3.5" inches wide

**EMBROIDERY COLOR:**

**On black tops:** White



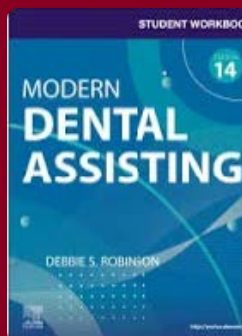
**ISBN:** 9780323882439

**Modern Dental Assisting**

**Author** Robinson

**Publisher** Elsevier Science &  
Technology Books

**Courses** DAE 100, 101, 105, 114, 128



**ISBN:** 9780443124037

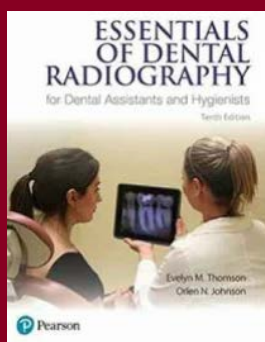
*\*MUST be free of any writing/markings.  
It is suggested that you purchase this  
book, since you will be writing in it.*

**Student Workbook for Modern Dental  
Assisting with Flashcards**

**Author** Robinson

**Publisher** Elsevier Health Sciences  
Division

**Course** DAE 100, 101, 105, 114, 128



**ISBN:** 9780134460741

**Essentials of Dental  
Radiography**

10<sup>th</sup> Edition

**Author** Thompson/Johnson

**Publisher** Pearson

**Course** DAE 111



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## MOHAVE COLLEGE - DENTAL ASSISTING STUDENT INSTRUCTIONS

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Background checks, drug testing, and immunizations are required to ensure the safety of patients treated by students in the clinical education program. The reports are typically completed within 3-5 business days; however, you must submit your order in sufficient time for the report to be reviewed by the program coordinator or associated clinical site prior to starting the rotation. The background check is conducted by PreCheck, Inc., a firm specializing in the healthcare industry.

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### **GETTING STARTED**

Follow this link to [MyStudentCheck](#)

*If you are unable to access the link, you may type in the web address located at the bottom of this page.*

- Confirm the school's name matches: **Mohave College - Dental Assisting**
  - Select your program from the drop-down menu, and then select the required services.
  - Log in with your username and password. If you do not have an existing profile, please create a new account.
  - Enter the required information, provide authorization, and continue to enter payment information.
  - If you need further assistance, please contact PreCheck at 877-214-5496.
  - You will be provided with a receipt and confirmation page when your order is placed.
- 

### **DRUG TESTING**

Pre-registration does not set an appointment time, we recommend calling your chosen collection site ahead of time to set up an appointment.

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### **IMMUNIZATIONS**

Your confirmation will contain a link to the immunization requirements and documents which should be presented to your physician for completion. Your name should be legible on all documentation. Once the documents are completed, please submit the forms to SentryMD at <https://mysentrymd.com/sentrymd.html#/upload>. You will receive confirmation that the upload was successful. Your Immunization Tracking order is good for the duration of your program. Email any questions about your immunizations tracking to: **Mohave@SentryMD.com**

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### **PRICING**

Background Check	<b>\$54.45</b>
Drug Test	<b>\$39.60</b>
Immunization Tracking –	<b>\$29.50</b>

*Applicable state sales tax will be collected based on your residential location.*

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### **FREQUENTLY ASKED QUESTIONS**

- 1. What does PreCheck do with my information?**  
Your information will only be used for the services ordered. Your credit will not be investigated and your name will not be given out to any businesses.
  - 2. I selected the wrong school, program or incorrect information.**  
Call the StudentCheck Team at 877-214-5496 with the details.
  - 3. Do I get a copy of the background report?**  
Yes, go to [www.mystudentcheck.com](http://www.mystudentcheck.com), log in, and select Check Status.
  - 4. How do I obtain a copy of the drug test report?**  
Go to [www.mystudentcheck.com](http://www.mystudentcheck.com), log in, and select Check Status.
  - 5. I have been informed that my immunization forms are deficient, what do I do?**  
Contact a SentryMD representative by emailing questions to **Mohave@SentryMD.com**.
  - 6. I was denied entry into a program because of information on the report, who can I contact?**  
Call PreCheck's Adverse Action hotline at 800-203-1654.
-

Information to pay attention to when registering for PreCheck, as they are part of the clinical health requirements.

**\* Choose college and appropriate Dental Assisting Course here.**

If your school program is not listed below, please submit your application by mail using the form provided by your school. If you are unsure of what package is needed, please contact your program director for assistance.

### School and Program

Mohave Community College - Dental Assisting

Dental Assisting

### Select Services

Background Check

Drug Test

Immunization

[Start Application](#)

**\* Create your PreCheck account here.**

### Create Account

First Name: Christine

Middle Name: N/A  No Middle Name

Last Name: Kowalewski

Email Address: c@precheck.com

Confirm Email Address: c@precheck.com

Password: \*\*\*\*\*

Confirm Password: \*\*\*\*\*

I agree to enroll in Healthcare Employment Opportunity Engagement. [Learn more](#)

[Create](#)

**Healthcare Employment Opportunity Engagement**

PreCheck partners with many of the nation's largest health systems. As a benefit to students that come through our StudentCheck program, we are offering you the opportunity to opt-in to have your name and contact information available to these hospitals and health systems for the purposes of inviting you for future interviews and engaging you about opportunities for employment and/or other assignments within their organization. If you choose to opt-in, we will not share your background results or any other elements of this process without your expressed consent.

**\* Choose drug screening location here.**

### Drug Testing - Lab Location

Please confirm your zip code and choose a convenient collection site from the list of approved providers.

Zip Code: 72088 [Search](#) [Cancel](#)

**Collection Site List - Please select a collection site**

NOTE: Many sites have specific hours indicated for drug screens. Please refer to the hours listed for a collection site. The specific times available for drug screens appear in the "Hours" column and typically appear after the term "DRUG SCREEN" or "UICP" (Urine Drug Screen). You may also click on the "Show More" link to view the full drug screen hours schedule.

Select	Site Name	Address	Phone	Hours
<input checked="" type="checkbox"/>	LabCorp - Houston - DeWitt (Dr. Labors)	5420 DeWitt Dr	713-755-0977	7A MON-FRI 9:00AM - 4:00PM
<input type="checkbox"/>	LabCorp - Houston - Frostwood (Dr. Labors)	855 FROSTWOOD DR	713-441-0337	MON-FRI 10:00AM - 4:00PM SA 10:00AM - 11:30AM
<input type="checkbox"/>	LabCorp - Houston - Southwest (Dr. Labors)	8113 SOUTHWEST Fwy	713-724-7992	10A MON-FRI 9:00AM - 4:00PM

[Schedule Me At The Site Chosen Above](#) [Show More Sites](#)

**\* After registering for drug screen, print this form and bring with you to testing site.**

Receipt for Scheduled Collection

[Print](#) [Close](#) [Re-Transmit Notifications](#)

Lab: labcorp  
Lab Confirmation No.: 303685011

Christine Kowalewski has been electronically scheduled for a drug screen and this screen does not require a paper chain of custody form. Please present this registration notification along with a government issued photo identification at any one of the following collection sites in your area on or before the expiration date referenced below.

Donor Information:  
Client: STUDENT CHECK (PRECHECK) - DEMO - DEMO Location  
Name: Kowalewski, Christine  
ID: \*\*\*\*\*2222

Lab Information:  
Lab: labcorp  
Lab Confirmation No.: 303685011  
Expiration Date: 6/4/2020 11:59 PM CST

The following collection site(s) in your area can perform the drug test sample collection. Clicking on the link will provide you with a map for your use. We advise that you contact the site first to verify the address and hours of operation.

Site Name	Address	Phone	Hours
LabCorp - Houston - DeWitt 5420 DeWitt Dr	5420 DeWitt Dr	713-755-0977	7A MON-FRI 9:00AM - 4:00PM

**\* Schedule your drug screen here.**

### Click to schedule

Please schedule your drug test by selecting your most convenient drug testing location and collection time by either completing the information in the box below or following the provided link. Some internet browsers will allow this action to be completed in the box below, while others will not display a box and you will need to follow the provided link instead. If there is no box displayed or an error message displayed in the box, please ensure that you click on the link and follow the instructions within the new page. If you click on the link and are not immediately taken to the new page, please ensure that your pop up blockers are disabled and then try the link again. If you do not wish to schedule at this time or are having issues with the form, please press the Next button to proceed with placing your order. A link to the drug test scheduling form will be provided on your confirmation page if you choose to skip this step.

[Please click here to schedule your Drug Test.](#)

**\* Schedule drug testing if missed previously under "Drug Testing" section.**  
**\* Packet of immunization requirements can be found in the "Immunization" section. You must print this packet and upload completed documents to SentryMD, directions are included in the packet.**

### Thank you for submitting your order.

**Confirmation**

A copy of this page has also been sent to the email address you provided. Thanks you for placing your order through StudentCheck. Please print this receipt and confirmation of your order placed through PreCheck, Inc. Your order has been submitted for processing; no refunds are available.

Name: Christine M Kowalewski  
Date order placed: 7/14/2021 8:07:09 AM  
Package/Services Purchased: BackgroundCheck DrugTest Immunization  
Order Confirmation Number: 5913656  
For: StudentCheck College Demo - LVN

(If this is not your correct school program, please provide correct program by contacting us at [StudentCheck@PreCheck.com](#))

**FCRA and Additional Notices**

Authorization  
Disclosure  
Notice Regarding Background Investigations Pursuant to California Law  
Summary of Your Rights Under the Fair Credit Reporting Act

**Drug Testing**

Pre-registration for drug test is required before heading to a collection facility. If you successfully completed this process, you should have selected a collection site and received a separate confirmation via email. If you did not complete the drug test pre-registration, please click/save this link ([DrugTest Registration](#)) to complete the pre-registration.

**Immunization**

**Further Action Required**

You have paid for the Immunization Tracking Service. You will now need to begin the process of providing your school required documents. Click to view a PDF copy of instructions for submitting your Immunization Records

**Adverse Action**

You will be notified if your application was denied because of the information in your report. You will be given instructions to call PreCheck's Compliance hotline at (800)203-1654. Adverse Action is the procedure established by the Fair Credit Reporting Act that ensures you receive a copy of your report and have the opportunity to dispute any inaccurate or incomplete information on your report.



## INFORMATION FOR STUDENTS IN HEALTH SERVICES PROGRAMS

The staff at Mohave County Department of Public Health are dedicated to helping you with some of the steps of that process. The Mohave County Department of Public Health offers services including, but not limited to, Tuberculin Skin Testing (TB), and vaccines for Hepatitis B, Measles, Mumps, and Rubella, Varicella, Tetanus, Diphtheria and Pertussis

They have office in Kingman, Bullhead City, Lake Havasu City and Colorado City Arizona. Please note: Adult vaccination clinics are once a week by appointment only

### OFFICE LOCATIONS

<b>Kingman</b>	<b>Bullhead City</b>	<b>Lake Havasu City</b>	<b>Colorado City</b>
700 W. Beale St. Kingman, AZ 86401 Phone: 928-753-0714	1222 Hancock Road Bullhead City, AZ 86442 Phone: 928-758-0703	2001 College Dr., Suite 115 Lake Havasu City, AZ 86403 Phone: 928-453-0703	2096 S. Hwy 389 Colorado City, AZ 86021 Phone: 928-875-8960

### What is offered

- TB testing/TST Placement

TB skin testing is \$36.00 - you must be able to return to the clinic 48-72 hours after the test is placed to receive your clearance

- Immunizations

Bring your insurance card and the county will bill your insurance. If it is not covered under your insurance or if you are currently uninsured, you may be eligible to receive the vaccine at no cost to you.

- Titers

Hepatitis B: \$92.00

MMR: \$170.00

Varicella: \$99.00

More pricing is available when you visit an office

### Steps to Start the Process

- Locate your Vaccination record: Go to MyIRMobile and search for your shot record, you can also stop by your local health department to get it.
- Bring your ID
- Get Labs if needed: You can order these tests with your Primary Care Provider, a lab or with the County.
- Call the Department of Public Health for immunizations (If needed) - If your titers is below the recommended label, they may be able to assist.

Dear Mohave College Student,

Welcome to the Sentry MD document tracking service. Mohave College has contracted with Sentry MD and our partners at PreCheck to store and maintain your student health requirements set by Mohave college. We are a confidential health record service. Students are required to provide proof of the listed health requirements in this packet to participate in the Dental Assisting Program. In this packet are the instructions on how to successfully complete the immunization and health requirements, please read carefully. Failure to provide complete health immunization documents may delay your entry or ability to participate in your program.

**Step 1:** Verify you have registered for the Mohave Community College Student Check Package:

- To activate your account, you must register for the student check package, if you have not yet completed your registration, please follow the bullets below:
  - Go to [www.mystudentcheck.com](http://www.mystudentcheck.com) and type 'Mohave College' in the program field
  - Select your program from the 'Program' drop down menu. Select Background Check, Drug Screen, and Immunization Tracking then click 'Start Application'.
  - Please enter all fields when prompted, and then complete your order. You will be emailed a receipt to the email address you provide.

**Step 2:** Gather Required Health Documents

- Begin by reading each immunization, titer, and additional document requirement listed on the following pages of this Health Requirement Packet ([Part I through VI](#)). It is important that you review this material carefully. All items are to be obtained and submitted to Sentry MD.

**Step 3:** Log in to your Sentry MD account to upload your documents and view your compliance status.

- Log in to Sentry MD at <https://mysentrymd.com/#/home>.
- Details on how to log in and navigate your account are under Part I on the following page.

If you have any questions regarding immunization requirements or the contents of this packet, please email us at [Mohave@SentryMD.com](mailto:Mohave@SentryMD.com).

For questions regarding Background Checks and Drug Testing, please contact [studentcheck@precheck.com](mailto:studentcheck@precheck.com).

**PART I SENTRY MD ACCOUNT** | *Log in to your Sentry MD account.*

**Link to Sentry MD Account:** <https://mysentrymd.com/#/home>

1. Enter your User ID: the email address you registered with.
2. Click on “Create password”
3. You will be sent a token to your email address
4. Enter Token from email onto site
5. Create a Password
6. Click the link to go to the login screen

Once you are logged in, you will land on the Electronic Release form. You will need to authorize this statement electronically to move forward into your account. Once authorized you will have access to your account tabs.

- **Profile-** The Profile Tab displays all requirements and their compliance status. A blue checkmark next to each of the requirements means you are compliant. Requirements with the red exclamation mark indicate you are missing documentation, and these items need your attention.
  - You can download the compliance summary, by clicking the Download PDF link.
  - To view your school’s requirements, click the Health Requirements link.
- **Documents-** The Document Tab displays all documents you have submitted to the system, you can view, print, or download these by clicking the grey icons. To download all documents in your file at once, click the Download Combined Document link.
  - To upload documents to your account, click the grey button, Choose File and select the document from your phone or computer to load. Check the box for the requirements your document contains then click Upload file. You will see the document at the top of the list as pending. You will receive a confirmation notice once the document has completed processing, please note processing can take 48 business hours.
- **Activity-** The Activity Tab displays all recent activity of your account. Including any electronic notices, you were sent, login dates, and compliance status changes.

We hope these tools help you stay on top of your status and keep you compliant with your program requirements.

**PART II: ADDITIONAL DOCUMENTS TO BE SUBMITTED**

- **BLS for Health Care Provider CPR:** Submit a copy of your CPR card.
  - ★ Only the Basic Life Support or (BLS) for Healthcare Provider course through the American Heart Association.
- **Health Professions Physical Form**



## Health Requirements Dental Assisting Program



**PART III HEALTH REQUIREMENTS** | *This must be completed by your health care provider **OR** submit original documentation for each requirement on your Doctor, clinic or hospitals forms. All immunizations must be current. Upload through your account once completed at <https://mysentrymd.com/#/home>.*

<b>Last Name:</b>	<b>First Name:</b>	<b>Date of Birth:</b>
<p><b>TB: Proof of Negative Tuberculosis within 1 year.</b> Initial Two Step PPD Tuberculosis Skin Test – Annual Single PPD required.</p> <ul style="list-style-type: none"> <li>1<sup>st</sup> skin test placed and read 48/72 hours later if negative 2<sup>nd</sup> skin test placed 7 to 21 days after the 1<sup>st</sup> read date. If skin test is positive Chest X-ray and annual evaluation for Positive PPD.</li> </ul> <p style="text-align: center;">or</p> <p>QuantiFERON Gold or Chest Xray with annual evaluation for TB symptoms.</p>		
<p><b>PPD 1 Plant Date:</b>    <b>PPD 1 Read Date:</b>          ___/___/___        ___/___/___  <b>Site:</b> <input type="checkbox"/>Left <input type="checkbox"/>Right <b>Result</b> ___mm <input type="checkbox"/>Neg  <input type="checkbox"/>Pos</p> <p><b>PPD 2 Plant Date:</b>    <b>PPD 2 Read Date:</b>          ___/___/___        ___/___/___  <b>Site:</b> <input type="checkbox"/>Left <input type="checkbox"/>Right  <b>Result</b> ___ mm <input type="checkbox"/>Neg <input type="checkbox"/>Pos</p>	<p><b>QuantiFERON Gold (Copy of Test Result required)</b></p> <p><b>Date:</b> ___/___/___  <b>Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/>Positive</p>	<p><b>Chest X-Ray</b></p> <p><b>Date:</b> ___/___/___  <b>Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/>Positive</p>
<p><b>Tetanus Diphtheria, Pertussis (Tdap): Tdap required within 10 years.</b>  <b>Tdap Vaccine Date</b> ___/___/___ <b>Proof of Vaccination Required</b></p>		
<p><b>Hepatitis B:</b> Serologic proof of immunity by Surface HBsAB titer for Hepatitis B. <u>Quantitative</u> lab report including values and reference range required. If titer is non-reactive (Negative or Equivocal) Hep B booster required with 2 dose history on file or Non-Immunity form is required.</p>		
<p><b>Hepatitis B surface (HBsAB) Titer</b>  <b>Date:</b> ___/___/___ <b>Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <b>Vaccinations accepted in place of titer blood draw for MMR, Varicella, and HepB</b></p>		
<p><b>Measles (Rubeola), Mumps, and Rubella (MMR):</b> Serologic proof of immunity by Surface Antibody IgG titers for Measles (Rubeola), Mumps, and Rubella. <u>Quantitative</u> lab report including values and reference range required. If titer is non-reactive (Negative or Equivocal) MMR booster required with 2 dose history on file or Non-Immunity form is required.</p>		
<p><b>Measles Titer Date</b> ___/___/___  <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>	<p><b>Mumps Titer Date</b> ___/___/___  <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>	<p><b>Rubella Titer Date</b> ___/___/___  <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>
<p><b>Varicella:</b> Serologic proof of immunity by Surface Antibody IgG titer. <u>Quantitative</u> lab report including values and reference range required. If titer is non-reactive (Negative or Equivocal) Varicella booster required with 2 dose history on file or Non-Immunity form is required.</p>		
<p><b>Varicella Titer</b>  <b>Date:</b> ___/___/___ <b>Result:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive</p>		
<p><b>Primary Provider AND Provider's stamp is required on this form to be accepted.</b>  <i>Provider's signature</i> _____  <b>Date:</b> ___/___/___</p> <p>Name (Printed) _____</p> <p>Telephone Number (____) ____ - _____</p>	<p>Place HCP Stamp Here</p>	

**PART IV STUDENT PHYSICAL FORM**

**Section 1 (to be completed by student.)**

Name (print): \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Allergies: \_\_\_\_\_

Medications currently taking: \_\_\_\_\_

**Section 2 (to be completed by Healthcare Provider)**

Height: \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_

Medical	Normal	Abnormal Findings
Appearance	<input type="checkbox"/>	
Eyes/Ears/Throat/Nose	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	
Lymph Nodes	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	
Murmurs	<input type="checkbox"/>	
Pulses	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Musculoskeletal	Normal	Abnormal Findings
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder/Arm	<input type="checkbox"/>	
Elbow/Forearm	<input type="checkbox"/>	
Wrist/Hands/Finger	<input type="checkbox"/>	
Hip/Thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg/Ankle	<input type="checkbox"/>	
Foot/Toes	<input type="checkbox"/>	

Notes: \_\_\_\_\_

Cleared Without Restrictions

Not Cleared for Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

	Healthcare Provider's Stamp Here
Healthcare Providers Name and Title (Please Print)	
Healthcare Providers Signature	
Date	

Recipient Name: \_\_\_\_\_  
*(Please Print)*

Date: \_\_\_\_\_

*Tuberculosis (TB) Screening Policy*

**Initial 2-Step Tuberculosis (TB) Screening**

All health profession students are required to have an initial 2-step TB screening, QuantiFERON-TB Gold blood test, or a chest x-ray upon admission to the program. If the test reading is negative, the second test is performed 1-3 weeks later. If the second test is positive the person is classified as “previously infected” and cared for accordingly.

Test #1		Test #2	
Name of Person giving test		Name of Person giving test	
Date and time administered		Date and time administered	
Location (circle)	L forearm      R forearm	Location (circle)	L forearm      R forearm
Tuberculin Manufacturer		Tuberculin Manufacturer	
Tuberculin exp. and lot #		Tuberculin exp. and lot #	
Administrator signature		Administrator signature	
Results (48-72 hours)		Results (48-72 hours)	
Date and time read		Date and time read	
Number of mm of induration: (across forearm)	_____ mm	Number of mm of induration: (across forearm)	_____ mm
Interpretation of reading (circle)	Positive      Negative	Interpretation of reading (circle)	Positive      Negative
Reader’s signature		Reader’s signature	

**Annual 1-Step Tuberculosis (TB) Screening**

		Results (48-72 hours)	
Name of Person giving test			
Date and time administered			
Location (circle)	L forearm      R forearm	Date and time read	
Tuberculin Manufacturer		Number of mm of induration: (across forearm)	_____ mm
Tuberculin exp. and lot #		Interpretation of reading (circle)	Positive      Negative
Administrator signature		Reader’s signature	

# Integrated Tuberculosis (TB) Screening and Risk Assessment Form for Health Profession Students

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Preferred Contact Information: \_\_\_\_\_

1. What position are you hired for? \_\_\_\_\_ What is your semester start date? \_\_\_\_\_
  
2. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.
  - a. YES, I have been in a foreign country for  $\geq 30$  days (**not including those listed above**)
  - b. NO, I have not been in any country for  $\geq 30$  days **except the ones listed above**
  
3. Have you had close contact with anyone who had active TB since your last TB test?  
YES / NO
  
4. Do you currently have any of the following symptoms?
  - a. YES / NO unexplained fever for more than 3 weeks
  - b. YES / NO cough for more than 3 weeks with sputum production
  - c. YES / NO bloody sputum
  - d. YES / NO unintended weight loss > 10 pounds
  - e. YES / NO drenching night sweats
  - f. YES / NO unexplained fatigue for more than 3 weeks
  
5. Have you ever been diagnosed with active TB disease?  
YES / NO
  
6. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
  - a. YES, one or more of these is true for me
  - b. NO, none of these is true for me
  
7. Have you been treated with medication for TB *or* for a positive TB test (e.g., taken "INH")?  
YES / NO  
If YES, what year, with which medication, for how long, and did you complete the treatment course?  
\_\_\_\_\_
  
8. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider)
  - a. YES, one or more of these is true for me
  - b. NO, none of these is true for me

\_\_\_\_\_  
Occupational Health Reviewer Signature

\_\_\_\_\_  
Date

- By signing this form, you are stating you understand that you are not immune to the following titer(s).
- You are stating that your exposure to patients at healthcare facilities with the following diseases puts you at risk of acquiring the disease.
- Most of the diseases are preventable through vaccines, you have had the opportunity to be vaccinated for; however, you choose at this time to decline the vaccination(s) checked below.
- You understand that by declining vaccine protection you continue to be at risk of acquiring the disease. You understand that you can receive these vaccines or tests at any time.

***Please note: copies of non-immune titers must be included with this form for acceptance as a clinical requirement.***

Non-Immune Titers	Reason
<input type="checkbox"/> MMR	_____
<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Rubella	_____
<input type="checkbox"/> Varicella	_____
<input type="checkbox"/> Hepatitis B	_____

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please Print)

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



Health Requirements  
Dental Assisting Program



**PART V RECEIPT OF STUDENT RESOURCES**

Mohave College provides several resources that guide expectations from our students. Please read and initial each line below acknowledging that you have reviewed and understand the resource and expectations for you.

- \_\_\_\_\_ 1. Mohave College Student Handbook (available at <https://catalog.mohave.edu>)
- \_\_\_\_\_ 2. Mohave College Student Code of Conduct (available at <https://catalog.mohave.edu>)
- \_\_\_\_\_ 3. Mohave College Catalog Program of Study for the program in which you were accepted (available at <https://catalog.mohave.edu>)

*\*Note, your catalog year will be for the term you START the program, not the term in which you applied.*

Student Name (Printed): \_\_\_\_\_ Mohave College ID: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PART VI ADDITIONAL HELPFUL INFORMATION

### Proof of Immunization

What is proof of immunization?

- Vaccine Documentation is required to have the following information:
  - Date administered
  - Vaccine Manufacturer
  - Vaccine Lot number and expiration date
  - Site of Injection
  - Name and Title of the person who administered the vaccine
  - Name and Address of the facility where the vaccine was administered

### Tuberculosis (TB) tests

What is a 2 step TB test?

- A 2-step TB test is two (2) different TB (PPD) tests with results for both tests.

What if I currently receive an annual TB test?

- You do not need to get a 2-step. You will provide instead two (2) annual TB (PPD) tests with copy of the latest TB test and results. After a year from the date the 2<sup>nd</sup> TB (PPD) was read, you will need to get an annual TB test. You are only required to get a 1 step TB (PPD) test.

What if I received a chest x-ray TB test?

- You will need to provide verification of the x-ray within a year stating negative results. After a year from the date of the x-ray you will need to complete an Annual Evaluation of positive PPD. You do not need to get another x-ray or TB test.

What if I received a titer blood draw named QuantiFERON Gold for a TB test?

- This type of test will take the place of a 2-step TB test. You will be required to get either a QuantiFERON Gold or a 1-step TB (PPD) test annually.

**Titer Blood Draw for: Measles, Mumps, Rubella, (MMR), Varicella and Hep B.**

What is a titer blood draw?

- Titer blood draw is completed to see if you are immune or not immune to MMR, Varicella, and Hep B.

How do I know if I am not immune?

- If you are not immune the titer result will state one of the following:

1. Non-Immune

F	Hep B Surface Ab, Qual	Non Reactive
		Non Reactive: Inconsistent with immunity, less than 10 mIU/mL

2. Non- Reactive

**Varicella zoster Antibody, IgG**  
**Varicella zoster Index**  
**Varicella zoster Antibody, IgG**

**0.6 L**  
**Negative \***

3. Negative

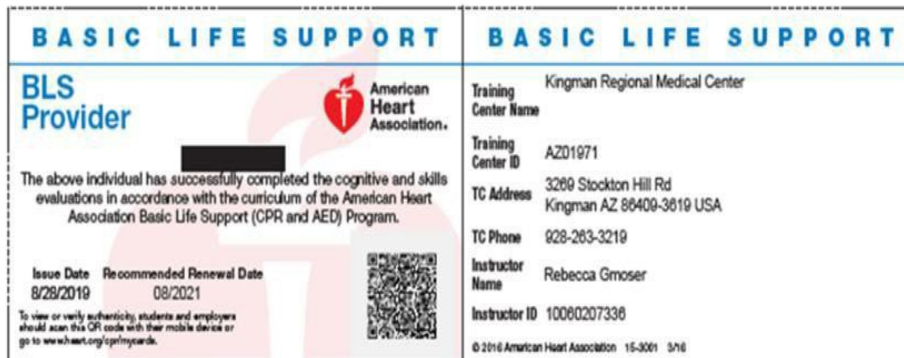
What do I do if I am not immune?

- You should receive an immunization booster for the non-immune titer (or) complete the non-immune form for the non-immune titer result.

## American Heart Association Basic Life Support CPR Card.

Is there a specific type of CPR certification/card required?

- Yes, you are required to have an American Heart Association - Basic Life Support (BLS) for healthcare providers.



Do I need to take a class to obtain a CPR card?

- Yes, if it is available, you can complete the BLS CPR class through the MCC RQI on every campus location.
- The RQI CPR carts website directions. Choose the link below to take you directly to the website to schedule your CPR certification.
- [Self-Guided CPR Certification](#)
- This program allows learners to earn their AHA CPR certification on their own time by combining online learning with a state-of-the-art simulation.
- The locations of the carts are listed on the webpage for each campus.
- The cost will be \$40



## Health Requirements Dental Assisting Program



**STUDENT CHECKLIST:** Please allow yourself plenty of time for your requirements to be reviewed in case you need additional, vaccines, tests, or certifications. **Once received, your documents can take 24 to 48 business hours to be processed.**

- The student has logged into the Sentry MD account ([Part I](#))
- Submit documentation of current BLS certification. ([Part II](#))
- Health Requirements in Part III are complete with dates of vaccines/titers and results are signed, dated, and stamped by your Health Care Provider. ([Part III](#))
- Physical Exam Form is complete, dated, signed/stamped by your Health Care Provider. ([Part IV](#))
- Receipt of Student Resources is initialed, signed, and dated. ([Part V](#))
- Please review the helpful information ([Part VI](#))
- Return your completed forms by uploading them as **one** PDF file into your account at <https://mysentrymd.com/#/home>.

Please email any questions you may have to [Mohave@SentryMD.com](mailto:Mohave@SentryMD.com)