PLEASE READ AND SIGN

THIS REGISTRATION FORM IS CONSIDERED A LEGALLY BINDING INSTRUMENT WHEN SIGNED BY THE ENROLLING STUDENT AND ACCEPTED BY RHONDA GRAY TRAINING CENTER, LLC

PLEASE READ BELOW REGARDING OUR REFUND POLICY.

ANY QUESTIONS OR PROBLEMS CONCERNING THIS SCHOOL THAT HAVE NOT BEEN SATISFACTORILY ANSWERED OR RESOLVED BY THE SCHOOL SHOULD BE DIRECTED TO:

The Department of Health and Human Services

We are registered with the State of Georgia to train unlicensed personnel in the field of Phlebotomy.

RGTC's REFUND POLICY: (AS OF January 1 st 2016) There will be no refunds of any payment made to RGTC for classes that the student is unable to attend. Deposits and/or payments may be used towards future classes upon approval by administrator only. A change in decision of class dates will incur a fee of $50.00.

As an adult signing this form, I fully understand that to successfully complete this course I will be required to complete the following: Read and study the text book material through hybrid, complete the assigned homework and pass the final exams with a grade of 80% or higher. I will also be expected to attend the entire clinical program including rotations, with documented proof of completed requirements as assigned (**if available**).

RGTC Policy:

Students are encouraged to notify the Administrator, in a timely fashion, with any health or emotional problems which may inhibit or delay completion of the program. Medical complication accompanied by a doctor's note or release will be acknowledged accordingly.

Any student who falsifies documentation may be subject to disqualification from the program. No refund will be given.

Any student caught cheating may be subject to disqualification for the program. No refund will be given.

Any student, who willingly and knowingly goes against RGTC Policy or Hospital Policy, may be subject to disqualification from the program. No refund will be given.

Any student who is unable or unwilling to complete clinical class or clinical rotation will be subject to disqualification from the program. No refund will be given.

_____ _____

STUDENT SIGNATURE DATE

STUDENT NAME **CLEARLY PRINTED** _____

POTENTIAL EXPOSURE TO CONTAGIOUS INFECTIOUS DISEASES

A portion of the RGTC Phlebotomy training is conducted in the laboratory/classroom setting. Students will perform blood withdrawal where contagious/infectious diseases may be present in any specimen, on any used equipment or spilled on any surface area during practice or demonstration. Latex/vinyl gloves will be supplied for protection; however, gloves are no guarantee against exposure. Your signature indicates that you are aware of the potential exposure to contagious infectious disease within phlebotomy laboratory training. Your signature acknowledges that you have knowledge and understanding of contagious/infectious diseases, such as, but not limited to AIDS, and HEPATITIS A, B, and C.

I UNDERSTAND THAT I AM ENROLLED IN A PHLEBOTOMY CLASS IN WHICH PARTICIPATION IN THE PRACTICE AND DEMONSTRATION OF VENIPUNCTURE AND BLOOD WITHDRAWAL EXPOSED ME TO THE POTENTIAL OF CONTAGIOUS / INFECTIOUS DISEASES. I ACKNOWLEDGE THAT I HAVE THE KNOWLEDGE AND UNDERSTANDING OF THE CONTAGIOUS / INFECTIOUS DISEASES TO WHICH I MAY BE EXPOSED.

CONFIDENTIALITY STATEMENT

I VERIFY, BY MY SIGNATURE, THAT I FULLY UNDERSTAND THAT ANY AND ALL PATIENT INFORMATION I MAY COME INTO CONTACT WITH, WHILE ATTENDING THIS CLASS, OR WHILE IN ANY HOSPITAL OR ANY LABORATORY, SHALL REMAIN CONFIDENTIAL. I UNDERSTAND THAT MANY DIFFERENT PEOPLE USE THESE HOSPITALS AND / OR LABORATORIES TO MEET THEIR HEALTHCARE NEEDS, AND THAT I MAY SEE PEOPLE THAT I KNOW OR KNOW OF WHILE AT ANY FACILITY. I FULLY UNDERSTAND THAT ALL PATIENTS HAVE THE RIGHT TO PRIVACY AND CONFIDENTIALITY WHILE RECEIVING MEDICAL TREATMENT. I UNDERSTAND THAT IT IS A PRIVILEGE TO BE ABLE TO USE THESE FACILITIES FOR CLASS TIME AND FOR THE BENEFIT OF HAVING ACCESSIBILITY TO A CLINICAL LAB. MY SIGNATURE ON THIS FORM STATES THAT I AGREE TO KEEP ALL PATIENT INFORMATION CONFIDENTIAL AND PRIVATE.

_____ _____

STUDENT SIGNATURE DATE

STUDENT NAME **CLEARLY PRINTED**_____

RELEASE OF LIABILITY

MY SIGNATURE ON THE LIABILITY, CONFIDENTIALITY, AND EXPOSURE FORM INDICATES THAT I FULLY UNDERSTAND THE FOLLOWING:

1. I MAY BE EXPOSED TO BLOOD BORNE PATHOGENS WHILE PERFORMING VENIPUNCTURE ON MY CLASSMATES.

2. I WILLINGLY AGREE TO ALLOW MY CLASSMATES TO PERFORM VENIPUNCTURE ON ME WHILE SUPERVISED BY MY INSTRUCTOR OR OTHER QUALIFIED CPT PERSONNEL.

3. I UNDERSTAND THAT IF I AM INJURED WHILE ON THE AMR, VHS OR ANY HOSPITAL OR LABORATORY PROPERTY THAT I AM FULLY RESPONSIBLE FOR SEEKING MEDICAL HELP AT A LOCAL MEDICAL FACILITY.
4. I AGREE TO NOT HOLD RHONDA GRAY RUBBINS-ARCENEAUX,RGTC, AMR, VHS OR DESIGNATED HOSPITAL OR LABORATORY OR THEIR EMPLOYEES RESPONSIBLE FOR ANY INJURY I MAY SUSTAIN.

5. I AGREE TO FOLLOW ALL SAFETY PRECAUTIONS THAT HAVE BEEN SET FORTH BY THE INSTRUCTOR.

6. I AGREE TO USE THE SHARPS CONTAINER APPROPRIATELY.

7. I AGREE TO NOT RECAP NEEDLES.

8. I AGREE TO WEAR GLOVES.

9. I AGREE TO WASH MY HANDS BEFORE AND AFTER USING GLOVES.

I UNDERSTAND MY NAME AND SOCIAL SECURITY NUMBER WILL BE USED TO OBTAIN A BACKGROUND CHECK AS REQUIRED BY HOSPITAL / LABORATORY CONTRACT.

_____ _____

STUDENT SIGNATURE DATE

_____

STUDENT NAME **CLEARLY PRINTED**

Confirmation of Liability, Confidentiality, Potential Exposure and Fee Statement.

I have read and acknowledged the release of liability, the patient confidentiality, potential exposure, and the replacement fee waivers. My signature below confirms my acceptance of the above mentioned policies and procedures page given to me in advance of class.
I have received the course curriculum presented by Rhonda Gray Training Center,LLC. and acknowledge that I must complete the entire program, which includes Basic, Advanced and Clinical courses. I understand that I must have all required documentation submitted, no more than 30 days from the last day of class or I will be subject to repeating and paying for, part or all of the above courses.

I understand, although our program is State certified, and the class hours completed lead to certification, as outlined by the guidelines; there are no academic credits or units that transfer to other educational institutions.

I understand my name and social security number will be used to obtain a background check as required by hospital/laboratory contract.

_____

Student Signature

_____

Student Name (Please Print Clearly)

_____

Date (FIRST class session)

Schedule of Replacement Fees:

Copy of Cert. $10.00

Original Cert. $30.00

Copy of Background Check $5.00(if you submitted one only)

Replacement Study Guide $25.00