Thank you for your interest in the Pre Pharmacy Technician program at Pontotoc Technology Center. Pharmacy Techs are taught in the classroom, with some job shadowing experience being provided in the pharmacy settings. Class includes 48 hours of theory & 16 hours of shadowing. Class will cover knowledge of theory and basic knowledge of pharmacy information systems, regulatory, legal and ethical considerations, drug calculations, terminology and other skills necessary to a pharmacy technicians’ job performance. This course will also prepare the student to competently take the certification exam. The PTCB candidate will have the opportunity following this course and working with a pharmacist to apply and take the exam. Within this packet you will find the required pre-requisite list which must be returned no later than the first scheduled day of class. Please fill out the required paper work to attend this class and return it to the BIS department as soon as possible. Refer to our website for a class dates and times www.pontotoctech.edu or pick up a hard copy of the schedule at PTC. Thank you again for choosing Pontotoc Technology Center and we hope to see you soon!

Business and Industry Programs
Dear Pre Pharmacy Tech Applicant,

Thank you for your interest in Pontotoc Technology Center’s Pre Pharmacy Technician program. This packet contains all the information and forms that you need to complete the application process. The requested information is critical for a student’s successful completion of our programs, because much of the information is required by the various organizations that we work with during your educational process. It is essential that you complete all of the forms and return the packet along with the required documentation before the application deadline. Only applicants with completed application packets will be enrolled into the program.

The forms and documents required for the application process can be confusing and the task of gathering the various documents can be time consuming. Applicants that wait till the last minute to complete the packet often are not accepted into the program. Allow yourself at least 3 weeks to complete the application.

Our staff and instructors are dedicated to helping you reach your career goals and the information that you provide us will ultimately determine your overall success in the program.

Several places can assist you with the required immunizations, including your personal physician and the local health department.

If you have any questions, please contact me at (580)310-2236.

Andrea Pogue, RN
Health Programs Coordinator
Pontotoc Technology Center
Pontotoc Technology Center
Pre Pharmacy Technician Course

Program Information:
The Pre Pharmacy Technician course includes 48 hours of classroom and 16 hours of job shadowing. Upon successful completion of this course the student is eligible to sit for the Pharmacy Technician Exam offered through the Pharmacy Technician Certification Board. Those who complete the course are prepared to work as a Pre Pharmacy Technician in the hospital or pharmacy setting. You will not be allowed to perform clinical it is only a job shadowing experience. You will not be a Pharmacy Technician until you have worked with a pharmacist for one year. For more information about the exam you can call PTCB at 1-202-429-7576 to request an application or you can apply online with a valid credit card at www.ptcb.org. The exam can be taken in OKC at a test site.

Entrance Requirements:
Students must apply for acceptance into the program prior to enrollment. All applicants must be 18 years or older. Students must be 18 years of age to sit for the State examination. Applicants must complete an application packet and return it to the Health Program Coordinator prior to the end of the application deadline.

Criminal History Report:
All Health Program applicants are required to provide a criminal history report. (instructions and form included). Only original forms sent to you from the OSBI will be accepted. Any “rap sheets” sent by the OSBI must be included with your application. This process can take up to three weeks by mail. The OSBI does accept requests in person and the process typically takes only a few minutes. You must have the fingerprint check run as well.

Immunizations:
All Health Program students are required to show proof of current immunizations (list and forms attached.). Applicants are reminded to follow the required list closely. If you have any questions about immunizations please contact the Health Programs Coordinator. For more information on Immunizations and vaccinations, visit the CDC website. www.cdc.gov

Payment Information:
Payment is required upon enrollment.
***Dropping, leaving, quitting or being removed from the program, no matter what the reason, will constitute a forfeiture of all tuition paid. No refunds after the first day of class regardless of attendance. No refunds on books or supplies.

Contact Information:
For additional information please contact the Health Programs Coordinator at (580)310-2236 or email at apogue@pontotocctech.edu.
Pontotoc Technology Center
Application Self Check Off Form

Applicant Name: ____________________________ Date: ____________

The following items are required for your acceptance into the Pre Pharmacy Tech Program. This page is provided for you to “check off” the items as you place them into your application packet. You must complete, sign and include this page along with all of the listed documents with your application forms for consideration of admission. Applicants may be given the opportunity to provide additional or corrected documentation prior to the start of class.

☐ Completed BIS Admission form
☐ Copy of valid state Driver’s License
☐ Show Social Security Card to person taking your packet
☐ Copy of Current Healthcare Provider CPR card
☐ Copy of H.S. Diploma, transcript or GED (or college transcript)
☐ Record of receiving first MMR immunization
☐ Record of receiving second MMR immunization
☐ Record of first Tuberculin Skin Test (use form in packet)
☐ Record of second Tuberculin Skin Test (use form in packet)
☐ Record of Chest X-Ray reading (only if positive Tuberculin Skin Test)
☐ Record of Hepatitis B series or completed Declination form
☐ Record of Varicella Immunization or Documentation form completed
☐ Copy of OSBI Background Check with fingerprints results (you must get results from OSBI)
☐ Signed Drug Screen Form:

I ____________________________ understand that the above requested items are a mandatory requirement of the Pre Pharmacy Tech Program. Failure to include ALL of these items in my application packet WILL result in my application being possibly rejected.

Student Signature: ____________________________ Date: ____________
## Business & Industry Services / Pontotoc Technology Center
### Enrollment Form

**PLEASE COMPLETE THIS SECTION IN FULL**

<table>
<thead>
<tr>
<th>COURSE DATE</th>
<th>COURSE NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI.</th>
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<th>SSN</th>
<th>E-MAIL</th>
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<tr>
<th>HOME PHONE</th>
<th>WORK PHONE</th>
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</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**PLEASE CHECK THE SCHOOL DISTRICT IN WHICH YOU LIVE.**

- [ ] Ada
- [ ] Allen
- [ ] Byng
- [ ] Latta
- [ ] McLish
- [ ] Pickett-Center
- [ ] Roff
- [ ] Sasaskwa
- [ ] Stonewall
- [ ] Tupelo
- [ ] Vanoss
- [ ] Other __________

**PLEASE CHECK THE HIGHEST EDUCATION LEVEL ACHIEVED.**

- [ ] (30) Less than a H.S. diploma
- [ ] (31) High School graduate
- [ ] (32) Some college, no degree
- [ ] (33) Technical diploma
- [ ] (34) Associate degree
- [ ] (35) Bachelor degree
- [ ] (36) Master degree
- [ ] (37) Doctorate degree
- [ ] (38) GED

**PAYMENT METHOD**

- [ ] Cash/Check/Money Order
- [ ] [ ] Discover
- [ ] [ ] Master Card
- [ ] [ ] Visa

**Receipt # __________**

**EMPLOYER’S NAME OR FUNDING AGENCY**

**PAYING OWN FEES (write Self-Pay)**

**IF MEMBER OF A VOLUNTEER FIRE DEPT. DOING FIRE FIGHTER TRAINING PLEASE LIST FIRE DEPARTMENT HERE**

**BIRTHDATE**

<table>
<thead>
<tr>
<th>RACE (PLEASE CHECK ALL THAT APPLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] (0) American Indian or Alaska Native</td>
</tr>
<tr>
<td>[ ] (1) Black or African American</td>
</tr>
<tr>
<td>[ ] (2) Hispanic/Latino</td>
</tr>
<tr>
<td>[ ] (3) White</td>
</tr>
<tr>
<td>[ ] (4) Asian</td>
</tr>
<tr>
<td>[ ] (5) Native Hawaiian or other Pacific Islander</td>
</tr>
<tr>
<td>[ ] (6) Other</td>
</tr>
</tbody>
</table>

**GENDER**

- [ ] Male
- [ ] Female

**Pontotoc Technology Center, in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and Title IX of the Education Amendment of 1972, does not discriminate on the basis of race, ethnicity, religion, national origin, age, gender, disability or veteran status in any of its policies, practices or procedures. These equal opportunity provisions include, but are not limited to admissions, employment, financial aid and student services.**

**THIS SECTION IS REQUIRED FOR CHICKASAW NATION EMPLOYEES ONLY**

**PLEASE CHECK ONE OF THE DIVISIONS BELOW:**

- [ ] (A) Division of Administrative Services
- [ ] (B) Division of Aging
- [ ] (C) Division of Arts and Humanities
- [ ] (D) Division of Communications
- [ ] (E) Division of Education and Training
- [ ] (F) Division of Facilities and Support
- [ ] (G) Division of Heritage Preservation
- [ ] (H) Division of Legal Services
- [ ] (I) Division of Program Operations
- [ ] (J) Division of Youth & Family Services
- [ ] (K) Division of Treasury
- [ ] (L) Other
- [ ] [ ] Division of Commerce (Chickasaw Enterprises)
- [ ] [ ] Division of Housing & Tribal Development
- [ ] [ ] Division of Health Systems

**CHICKASAW EMPLOYEE SIGNATURE**

[Signature]

**NAME OF YOUR DEPARTMENT**

**JOB TITLE**

[Title]

**SUPERVISOR SIGNATURE:**

[Signature]

ACCOUNT NUMBER: ____________________

RETURN TO: Chickasaw Nation Training Division
CONSENT FOR HEALTH PROGRAMS DRUG/ALCOHOL SCREEN:
(Applicant will read each statement and sign below. Pontotoc Technology Center reserves the right to deny a student admission to any Medical Program if student refuses to sign this consent form.)

1. In applying for admission to any medical program at Pontotoc Technology Center, I understand that a drug/alcohol screening test could be administered based on suspicion of drugs or alcohol at school or at a clinical site.

2. The drug/alcohol test will consist of an initial screening test and a confirmatory test for any sample that produces a positive result. The drug/alcohol testing is to be done within 24 hours of suspicion. Once you enter the drug testing facility, you cannot leave the facility until the sample is collected.

3. The undersigned hereby authorizes the designated drug testing facility to perform a drug/alcohol screening test as a requirement to stay in any medical program if suspicion exists.

4. I understand the presence of chemical substances in my body fluids may result in dismissal from any medical program at Pontotoc Technology Center.

I hereby authorize that the results of the drug/alcohol screening test be given to officials at Pontotoc Technology Center for review of continued enrollment in the medical programs. I release and hold Pontotoc Technology Center, its agents, and employees harmless for any action in taking or testing of the sample. I also release and hold harmless Pontotoc Technology Center, its board of education, superintendent, management, instructors, or any other agent or employee for the use of any information received as a result of the screening test process.

I also acknowledge that an offer of admission and continued enrollment to any health program will be contingent upon my submission to and the subsequent results of this drug/alcohol screen.

__________________________________________
Printed Name

__________________________________________
Applicant Signature

__________________________________________
Date
Pontotoc Technology Center
PPD/TST Form

Student Name: ________________________________

Date: _______________  Time: _______________

Location (circle):  Left or Right  Forearm or Trapezius

Medication used: _______________

Lot #: _______________

Signature: __________________________________

Reading

Date: _______________  Time: _______________

Reactive _____  Non-Reactive _____

Signature: __________________________________

Pontotoc Technology Center
PPD/TST Form

Student Name: ________________________________

Date: _______________  Time: _______________

Location (circle):  Left or Right  Forearm or Trapezius

Medication used: _______________

Lot #: _______________

Signature: __________________________________

Reading

Date: _______________  Time: _______________

Reactive _____  Non-Reactive _____

Signature: __________________________________
Varicella (Chicken Pox) Documentation

Varicella Immunization (chicken pox) or signed documentation with dates of disease. If no immunization or dates of disease are available a titer test may be required.

I ________________________________ do verify that

(Signature of Student or Signature of Parent/Guardian)

_________________________________________ had the disease

(STUDENT NAME- PLEASE PRINT)

Varicella (also known as Chicken Pox) in 19____ at the age of ______.

(SIGNATURE)

Hepatitis B Declination

Name: ________________________________

Program: ______________________________

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 (HBV) infection. I have received information about hepatitis B vaccine, and I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. I further understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. 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 make my own arrangements to receive the vaccine.

☐ I decline hepatitis B vaccine.

☐ I have already received the hepatitis B vaccine.

Signature: ________________________________ Date: ____________________
OKLAHOMA STATE BUREAU OF INVESTIGATION
Criminal History Record Information Request
6600 North Harvey Place
Oklahoma City, OK 73116
(405) 848-6724
(405) 879-2503 FAX
http://www.ok.gov/osbi/Criminal_History/

DATE
Request Submitted via:
Fax [ ] Mail [ ] In Person

Type Of Search Requested:
[ ] Name Based - $15.00
[ ] Sex Offender - $2.00
[ ] Mary Rippy Violent Offender - $2.00
[ ] State Fingerprint-based - $19.00
  * Must provide fingerprint card.
  * Includes name based search.

Requests will be returned in the manner received.
Mail requests should include postage-paid reply envelope.
Fax requests must include payment by credit card and a dedicated Fax Phone Line for return of completed search.

Acceptable Forms of Payment:
[ ] CASH [ ] CASHIER’S CHECK / MONEY ORDER
[ ] BUSINESS CHECK [ ] CREDIT CARD
  No Personal Checks Accepted.
  For Visa, MasterCard and Discover, security code is 3 digits on back of card.
  For Amex, security code is 4 digits on front. These are the only cards accepted.

CREDIT CARD # ____________________________ EXPIRATION DATE ____________ SECURITY CODE ____________
CARD HOLDER ____________________________
Please print the name of the individual card holder as it appears on the credit card.
CARD HOLDER SIGNATURE (REQUIRED) ____________________________

REQUESTOR INFORMATION: (Type or print clearly in blue or black ink)

REQUESTOR’S NAME ____________________________ SIGNATURE OF REQUESTING PARTY ____________________________

STREET ADDRESS ______________________________________

PHONE NUMBER ( ) ____________________________ E-MAIL ADDRESS ____________________________
CITY ______ STATE ______ ZIP ______

Requests outside of the United States are strongly encouraged to provide an e-mail address for purposes of correspondence.

PURPOSE OF REQUEST ____________________________

SUBJECT INFORMATION: (Type or print clearly in blue or black ink)
Forms with corrections done with white out or by striking through the fields in this section will not be processed.

NAME ____________________________ ____________________________ ____________________________
LAST FIRST MIDDLE

ALIAS/MAIDEN NAME(S) ____________________________

DATE OF BIRTH ____________________________ (MM/DD/YYYY). If date of birth is unavailable, include exact age of subject.

RACE ______ SEX ______ SOCIAL SECURITY NUMBER ____________________________

SEARCH RESULTS (Please do not write in the spaces below):

Oklahoma State Bureau of Investigation
Computerized Criminal History

Oklahoma Department of Corrections
Sex Offender

Oklahoma Department of Corrections
Violent Offender

Unless fingerprint cards are provided, record information is furnished solely on the basis of name or description similarity with the subject of your inquiry.

For questions on the Sex Offender / Violent Offender Registry, please contact the Oklahoma Department of Corrections.

OSBI CHER 08/09
HEALTH PROGRAMS CRIMINAL RECORDS CHECK POLICY

Health care providers are entrusted with the health, safety, and welfare of patients; have access to controlled substances and confidential information; and operate in settings that require the exercise of good judgment and ethical behavior. Clinical facilities are increasingly required by accreditation agencies, such as Joint Commission for Accreditation of Healthcare Organizations (JACHO), to conduct background checks on individuals who provide services within the facility and especially those who supervise records check for all prospective employees for positions where the individual will be caring for older adults or children.

Clinical learning experiences are an essential element of the curriculum of health care programs. All students enrolled in Pontotoc Technology Center’s health care programs must successfully complete a criminal records check as a criterion for participating in clinical courses. Participation in clinical courses is required for progression and completion of health care programs.

The check must be completed by the Oklahoma State Bureau Investigation (OSBI). The criminal records check must be completed within the six months immediately prior to the student’s entry into clinical courses. The student shall be responsible for all costs associated with the criminal records check.

The information provided in the criminal records report will only be used to evaluate the student’s qualifications for entry into clinical courses. Reports will be kept in secured confidential files separate from the student’s academic file with access limited to approved members of the Adult Training and Development Division.

Criminal record reports will undergo administrative review. If a student has been convicted of or pled guilty to a disqualifying offense (or any substantially equivalent offenses in any state), the student may be unable to complete clinical learning experiences and may therefore be disqualified from admission, readmission, or progression in the health care program. Some of the disqualifying offenses are absolute bars while others might bar the student from admission, readmission or progression in the program. The absolute and potentially disqualifying offenses are listed in the table attached to this packet.

In the event that the student’s background check includes a disqualifying offense, the student will be asked to schedule a meeting with the Program Coordinator to discuss the information received. If the background check identifies offenses that the student considers incorrect, the concerns or issues must be addressed, by the student, to the Oklahoma State Bureau Investigation for resolution. If the background check identifies offenses that may preclude admission, the student will be given an opportunity to respond to the information. Relevant considerations may include but are not limited to: the date, nature and number of convictions; the relationship the conviction bears to the duties and responsibilities of the health care provider; and successful efforts toward rehabilitation. The decision to allow or disallow participation in a clinical course for a student whose background check includes a disqualifying offense is solely at the discretion of the Program Coordinator and the Director of Business and Industry.

All students who are admitted to a health care program have a continual obligation to report any criminal conviction that may impact the student’s continued ability to participate in the clinical program to the Program Coordinator or the Director of Business and Industry within 30 days of its occurrence. Failure to do so will result in immediate dismissal from the program.
<table>
<thead>
<tr>
<th>Aggravated Murder</th>
<th>Compelling Prostitution</th>
<th>Unlawful Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murder*</td>
<td>Promoting Prostitution</td>
<td>Endangering Children</td>
</tr>
<tr>
<td>Voluntary Manslaughter*</td>
<td>Procuring</td>
<td>Contributing to the Unruliness or Delinquency of a Child</td>
</tr>
<tr>
<td>Involuntary Manslaughter</td>
<td>Prostitution</td>
<td>Domestic Violence</td>
</tr>
<tr>
<td>Felonious Assault*</td>
<td>Disseminating Matter Harmful to Juveniles</td>
<td>Prohibition of Conveyance of Certain Items onto Grounds of Detention Facility or Mental Health or Mental Retardation and Developmental Disabilities Facility.</td>
</tr>
<tr>
<td>Aggravated Assault</td>
<td>Pandering Obscenity</td>
<td>Carrying Concealed Weapons</td>
</tr>
<tr>
<td>Assault</td>
<td>Pandering Obscenity Involving a Minor</td>
<td>Having Weapon while under Disability</td>
</tr>
<tr>
<td>Failure to Provide for a Functionally Impaired Person</td>
<td>Pandering Sexually Oriented Matter Involving Minor</td>
<td>Improperly Discharging a Firearm/Habitation or School</td>
</tr>
<tr>
<td>Aggravated Menacing</td>
<td>Illegal Use of a Minor in Nudity-Oriented Material or Performance</td>
<td>Corrupting Another With Drugs</td>
</tr>
<tr>
<td>Patient abuse or neglect</td>
<td>Aggravated Arson*</td>
<td>Drug Trafficking Offenses</td>
</tr>
<tr>
<td>Kidnapping*</td>
<td>Aggravated Robbery*</td>
<td>Illegal Manufacturing of Drugs</td>
</tr>
<tr>
<td>Abduction</td>
<td>Robbery</td>
<td>Funding Drug Trafficking</td>
</tr>
<tr>
<td>Child Stealing</td>
<td>Aggravated Burglary*</td>
<td>Illegal Administration or Distribution of Anabolic Steroids</td>
</tr>
<tr>
<td>Criminal Child Enticement</td>
<td>Burglary</td>
<td>Drug Abuse</td>
</tr>
<tr>
<td>Coercion</td>
<td>Breaking and Entering</td>
<td>Permitting Drug Abuse</td>
</tr>
<tr>
<td>Extortion</td>
<td>Theft, Aggravated Theft</td>
<td>Deception to Obtain Dangerous Drugs</td>
</tr>
<tr>
<td>Rape*</td>
<td>Unauthorized Use of a Vehicle</td>
<td>Illegal Processing of Drug Documents</td>
</tr>
<tr>
<td>Sexual Battery*</td>
<td>Unauthorized Use of Property/Unauthorized Access to Computer Systems</td>
<td>Adulteration of Food</td>
</tr>
<tr>
<td>Corruption of a Minor</td>
<td>Passing Bad Checks</td>
<td></td>
</tr>
<tr>
<td>Gross Sexual Imposition*</td>
<td>Misuse of Credit Cards</td>
<td></td>
</tr>
<tr>
<td>Sexual Imposition</td>
<td>Forgery</td>
<td></td>
</tr>
<tr>
<td>Importuning</td>
<td>Medicaid Fraud</td>
<td></td>
</tr>
<tr>
<td>Voyeurism</td>
<td>Securing Writings by Deception</td>
<td></td>
</tr>
<tr>
<td>Public Indecency</td>
<td>Insurance Fraud</td>
<td></td>
</tr>
<tr>
<td>Felonious Sexual Penetration</td>
<td>Receiving Stolen Property</td>
<td></td>
</tr>
</tbody>
</table>

*Absolute disqualifying offense