Massage Therapy Program Admission Form (Fall Semester Start)
Priority deadline for this application is June 1st every year

1. Be registered for or have completed the following pre-requisite courses with a minimum of a C- grade.
   - Massage Therapy Career Exploration MSTH 0100
   - Introduction to Anatomy and Physiology HO 0111
   - Medical Terminology HO 0106
   If you do not complete these courses with a C- or above, you will not be eligible to start the program.

2. Meet with a College of Technology Student Services advisor to verify successful registration for/or completion of prerequisite courses. (For summer semester students, you must meet with an advisor at mid-term.)
   - An acceptance letter will be mailed to you from Student Services.
   - Submit a $75 deposit at the Student Services office.
   - Meet with a College of Technology Student Services Advisor to verify successful registration for/or completion of prerequisite courses.

   ___________________________ Signature from Student Services Health Occupations Advisor
   - Meet with Program Coordinator to discuss application details.

   ___________________________ Signature from Program Coordinator
   If you have any questions about steps 1 or 2 contact Student Services at (208) 282-2622.

3. Provide this completed form with Student Services Advisor signature along with the following documentation to the Massage Therapy Program Coordinator. www.isu.edu/massagetherapy/program-forms/
   - Apply for the Certified Background check at www.CertifiedBackground.com.
   - Package Code: ID41 (PROVIDE RECEIPT)
   - Receipt for receiving 1 massage
   - Health history/health evaluation form completed
   - Health Care Provider CPR & First Aid Documentation (Must be completed before fall entry)

The forms have been filled out truthfully to the best of my ability and knowledge. If I plan to withdraw from the program before my start date, I will notify both the Program Coordinator and Student Services. I attest to the accuracy of the above information.

Printed Name
Bengal Id #
Date

Signature
Address

Phone
email

Massage Therapy Program Coordinator: Susan Beck, MTD, LMT, BCTMB
208-282-4287    email: becksus2@isu.edu
College of Technology #48, Room 144-146
MEDICAL HISTORY AND PHYSICAL EXAMINATION

Program of Study: MASSAGE THERAPY
Department: Health Occupations
Susan Beck, MTD,LMT,BCTMB
MT Program Coordinator
Campus Stop 8380
Pocatello, ID 83209-8380

STUDENTS PLEASE COMPLETE BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

REPORT OF MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Sex: M/F</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Number &amp; Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Date of Birth</th>
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</thead>
</table>

PERSONAL HISTORY
Please check those which you have had or now have

<table>
<thead>
<tr>
<th>Have You Had</th>
<th>Yes</th>
<th>Date</th>
<th>Comments</th>
<th>Have You Had</th>
<th>Yes</th>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Injury with Unconsciousness</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
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<tr>
<td>High or Low-Blood Pressure</td>
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<td></td>
<td>Heart Condition</td>
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<tr>
<td>Back Problems</td>
<td></td>
<td></td>
<td></td>
<td>Jaundice</td>
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<tr>
<td>Stomach, Intestinal, Gallbladder Trouble</td>
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<td>Disease or Injury of Joints</td>
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<tr>
<td>List All Operations:</td>
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<td></td>
<td></td>
<td>Kidney Disorder</td>
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<tr>
<td>List Current Medications</td>
<td></td>
<td></td>
<td></td>
<td>Allergy: Asthma</td>
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<td></td>
<td></td>
<td></td>
<td>Hay fever</td>
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</table>

I hereby declare that I have no illnesses or emotional problems not discussed with my physician that will interfere with my enrollment in the program. I hereby grant permission for the information requested on this form to be released to the College of Technology Health Occupations Department.

Applicant’s Signature __________________________ Date __________________________

College of Technology
Department of Health Occupations
Revised 4/4/18
HEALTH CARE PROVIDER PLEASE COMPLETE

REPORT OF HEALTH EVALUATION

BP _____  Height _____  Vision-Right 20/ _____  Corrected-R 20/ _____  Left 20/ _______
Weight _____  Corrected-L 20/ _______

ARE THERE ANY ABNORMALITIES?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>Describe</th>
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</thead>
<tbody>
<tr>
<td>1. Head, Ears, Nose or Throat</td>
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<tr>
<td>2. Respiratory</td>
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<td>3. Cardiovascular</td>
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<td>4. Gastrointestinal</td>
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<td>5. Hernia</td>
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<td>6. Eyes</td>
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<td>7. Genitourinary</td>
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<td>8. Musculoskeletal</td>
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<td>9. Metabolic/Endocrine</td>
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<td>10. Neuropsychiatric</td>
<td></td>
<td></td>
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<tr>
<td>11. Skin</td>
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</tbody>
</table>

HEPATITIS B
+ Positive Titer
- Negative Titer
Attach lab result
Negative titer requires further evaluation

INFLUENZA
Yearly vaccine
August – March

MMR
2 documented doses OR proven serologic immunity to all three
Attach copy of vaccine administration record OR attach lab result

Tdap
Booster as an adult within the last 10 years
Attach copy of vaccine administration record

VARICELLA
2 documented doses OR proven serologic immunity
Attach copy of vaccine administration record OR attach lab result

TB
Skin Test (PPD) mm induration (>10 mm is +)
OR IGRA + or –
Attach copy of document OR IGRA lab result
If positive* CXR attach report from radiology

Please refer to ISU screening recommendations for details about serologic immunity, vaccines, and TB screening

Is the patient now under treatment for any medical or emotional condition? Yes _____ No _____
Does this person have any limitations regarding lifting and moving of people and or equipment? Yes _____ No _____
In your opinion, does this applicant have the mental and physical health to meet the requirements of being an active and successful student in the Health Occupations Department as well as for being employed professionally following graduation? Yes _____ No _____

Comments:

_______________________________________________________  ________________________________________  ________________________________________

Physician’s Signature  Date  Address

_________________________________________________________________  ________________________________________________________________

Print Name  Phone

College of Technology  Department of Health Occupations  Revised 4/4/18
Order Instructions for
Idaho State University - College of Technology
Health Occupations

1. Go to https://mycb.castlebranch.com/
2. In the upper right hand corner, enter the Package Code that is below.

Package Code ID41: Background Check

About

About CastleBranch
Idaho State University - College of Technology Health Occupations and CastleBranch – one of the top ten background screening and compliance management companies in the nation – have partnered to make your onboarding process as easy as possible. Here, you will begin the process of establishing an account and starting your order. Along the way, you will find more detailed instructions on how to complete the specific information requested by your organization. Once the requirements have been fulfilled, the results will be submitted on your behalf.

Order Summary

Payment Information
Your payment options include Visa, Mastercard, Discover, Debit, electronic check and money orders. Note: Use of electronic check or money order will delay order processing until payment is received.

Accessing Your Account
To access your account, log in using the email address you provided and the password you created during order placement. Your administrator will have their own secure portal to view your compliance status and results.

Contact Us
For additional assistance, please contact the Service Desk at 888-723-4263 or visit https://mycb.castlebranch.com/help for further information.