



**School of Health Sciences
Diagnostic Medical Sonography Program**

Acceptance Form

I _____ (**print name**), **ACCEPT** the position as a student in the Diagnostic Medical Sonography Program. I understand that final acceptance depends upon successful completion of the final steps of enrollment, as outlined in the acceptance letter, including the required health physical, drug screening, and criminal background check.

I have received the DMS Program and School of Health Sciences Handbooks, and agree to abide by the guidelines and policies of the Diagnostic Medical Sonography Program and the School of Health Sciences.

PRINT NAME: _____

SIGNATURE: _____ *DATE:* _____

I, _____ **DECLINE** the position as a student in the Diagnostic Medical Sonography Program.



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Statement of Expectations

As a college student, you now have control of your destiny. A college education not only prepares you for a profession, but it is also an important step in making you a more productive member of society. Miami Dade College takes great pride in offering a high quality and challenging learning environment that will expose you to myriad opportunities for discovery and growth. You can expect:

- Excellence in teaching
- Encouragement of innovation and creativity
- A free exchange of ideas
- Respect for cultural diversity
- A comprehensive array of services to maximize your academic success

You also play a central role in fostering and maintaining a quality academic environment for yourself and others. Consequently, you are expected to:

- Attend classes regularly and on time
- Succeed and do well in your classes
- Strive for personal excellence
- Treat others with courtesy and respect
- Contribute to the marketplace of ideas at the College
- Demonstrate personal and academic integrity in your dealings with others
- Make a positive contribution to the multicultural, multiracial environment at the College
- Share responsibility for maintaining the integrity of the physical surroundings

Your enrollment here is a social contract between you and the College to become partners in your success. Good luck!

The mission of Miami Dade College is to provide accessible, affordable, high-quality education by keeping the learner at the center of decision-making and working in partnership with its dynamic, multicultural community.



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Program Handbook

I have received and read the Diagnostic Medical Sonography program handbook at Miami Dade College.

I agree to abide by the rules and policies of the program and the clinical sites I will be rotating through.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____



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Student Confidentiality Statement

As a student enrolled in a Miami Dade College health care program, I am aware of my responsibility for maintaining confidentiality of patient information that may become available to me in the course of my studies. Such information is protected and confidential under applicable federal and state laws and affiliation agreements between the College and affiliating health care agencies.

I will not reveal any patient information to any third party, except as authorized by law or as authorized by the affiliating agency. I will not use any patient identifying information, such as name or initials, on paperwork or electronic transmissions submitted to the College in the course of my studies. I will only discuss patient information or a patient's medical condition at the affiliating agency in settings away from the general public and only with authorized personnel at the affiliating agency. I further understand that in a classroom setting I will only discuss patients and their medical conditions in a manner that does not in any way identify the patient.

I agree to comply with all patient information privacy policies and procedures of Miami Dade College and the affiliating agency. I understand that violating this Confidentiality Statement may result in criminal and civil penalties against me for violating federal and state patient information privacy laws.

Dated this _____ day of _____ 20__

Student Name (Print)

Student Signature

Student Number

Witness



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Document Release Form

I (print student name) _____ give permission to the Diagnostic Medical Sonography Program to release health records to the clinical education sites that I will be assigned to for clinical practice during the two years of the program. I understand that without this information I will not be allowed to participate in any clinical rotation or be part of the DMS program.

Student's Signature _____ Date: _____

Clinical Coordinator's Signature _____ Date: _____
Carmen R. Feldman, MS, RDMS, RT (R)



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Medical Accident Insurance

Students in the School of Sciences are at risk of exposure to infected blood and body secretions. Students are required to purchase medical accident insurance for treatment that may be necessary as a result of unexpected exposure to infectious materials. Coverage is provided through the Florida Community Collegues' Risk Management Consortium. Students are required to purchase this coverage once each academic year. A special fee is assessed at the time of registration. In addition, students are encouraged to carry their own personal health insurance.

I have read and understand the need for Medical Accident Insurance while in the School of Sciences at MDC.

Signature: _____ Date: _____

PRINT NAME: _____

Student #: _____



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PROOF OF MEDICAL INSURANCE

As a student enrolled in the Diagnostic Medical Sonography Program at Miami Dade College, I understand that before I am permitted to be scheduled for any clinical experience, I must comply with **ONE** of the following:

_____ I will provide proof of health insurance purchased on my own by submitting a copy of the insurance membership card.

OR

_____ I will provide proof that I have purchased the on-campus health insurance by submitting a copy of the insurance membership card.

OR

_____ I will not provide proof of health insurance, and by my signature below indicate my understanding that any and all health care costs incurred by me which are not covered by the College's Accidental Insurance Coverage during any form of the program coursework is solely my responsibility. I will not attempt to bill Miami Dade College or any of its clinical facilities.

Student Name (print)

Student Number

Student Signature

Date



School of Health Sciences
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CAMPUS RESEARCH DATA SHEET

1. PERSONAL INFORMATION

MDC Student Number _____ Social Security Number _____ (last four digits)

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Home Telephone _____ Work Telephone _____

II. CAMPUS RESEARCH DATA

Please provide the following ethnic-race, sex, and citizenship data which are required by Federal and relevant accreditation agencies. Miami-Dade College is open to all regardless of sex, race, color, natural origin or handicap. This data sheet will be detached from your application and not forwarded to the screening committee

Please Check One Item in Each Category

Ethnic – Race Origin

- 1. ___ Non-Hispanic White
2. ___ Non-Hispanic Black
3. ___ Hispanic White
4. ___ American Indian
5. ___ Alaskan Native

Citizenship

- 1. ___ United States Citizen
2. ___ Resident Alien
3. ___ Refugee
4. ___ Student Visa (Specify)

SEX

- 1. ___ Male
2. ___ Female

Native Language

- 1. ___ English
2. ___ Spanish
3. ___ French
4. ___ Creole
5. ___ Other



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Student Fact Sheet

Student ID Number	
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Name

Address

City	State	ZIP
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Home Phone # Cell #	Alternate Contact (Name and Phone)
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E-mail Address

Gender	M	F			
Marital Status	Single	Married	Divorced	Separated	Widowed
DOB			Age	# Dependents	

Ethnicity (Based on Department of Education Categories)

	American Indian or Alaskan Native
	Asian or Pacific Islander
	Black Non-Hispanic
	Mexican American
	Puerto Rican
	Hispanic Other
	White

Do you receive any type of Financial Aid such as Scholarship, Loan, PIC, or Grant?

Y	N
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Have you ever worked in the health care field?

Y	N
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Do you own or have access to an off campus computer with internet access?

Y	N
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Student Information Sheet			
Name:		Date:	
Address:		Apt. #	
City:	State:	Zip:	
Day Phone:	Evening:	Gender: M or F	Cell:
DOB	E-mail:	Student #	
Race: _____ White non-Hispanic _____ Black non-Hispanic _____ White Hispanic _____ Black Hispanic _____ Native American/Alaskan native _____ Asian or Pacific Islander _____ Other: _____	Marital Status: _____ Single _____ Married Spouse's Name: _____ Employer: _____ Address: _____ _____ Phone: _____ Number of Children: _____		

Emergency Contact Information		
Notify:		H. Phone:
Relationship:		W. phone:
Address:		Cell #:
City	State:	Zip

Emergency Contact Information (Someone not residing with you)		
Notify:		H. Phone:
Relationship:		W. phone:
Address:		Cell #:
City	State:	Zip

(If any of the above information changes, please inform the Program Coordinator)

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