Division of
WORKFORCE PARTNERSHIPS

Registration Form for Hospital-based Massage Training

ALL MAILED REGISTRATIONS must be sent to:
CCRI, Division of Workforce Partnerships
1762 Louisquisset Pike, Lincoln, RI 02865-4585
Phone: 401-333-7070

CCRI ID # [ ][ ][ ][ ][ ][ ][ ][ ]

If you do not have a CCRI ID, or do not know it, please leave this field blank. We will assign one and enter this information for you.

_____/_____/_____
DATE OF BIRTH (Required)

LEGAL NAME (Last, First, Middle) ____________ MAIDEN NAME (If Applicable) ____________

STREET ______ CITY ______ STATE ______ ZIP CODE ______

(_____)__________ HOME PHONE

(_____)__________ CELL PHONE

E-MAIL ADDRESS __________

CRN #	COURSE #	COURSE TITLE	FEE
	PSEM-8034-	Hospital-based Massage Training	$595*
	PSEM-8033-	Application Fee (non-refundable)	$25
Location / Dates / Days:			
*The price will increase to $695, plus a $25 application fee after the registration deadline.		Total	$620

Optional: The following information helps us comply with federal statistical requirements only and will not, in any way, impact an enrollment decision. Federal regulations require colleges to report enrollment data by racial, ethnic and gender categories.

Gender: ☐ Male ☐ Female
Ethnicity: ☐ Not Hispanic ☐ Hispanic or Latino
Race: ☐ American Indian or Native American ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Note: Community College of Rhode Island is a state-supported agency; therefore, tuition and fees are subject to change at any time. Waivers are not applicable to the Division of Workforce Partnerships courses. Payments in full must be made at the time of registration. Make checks payable to Community College of Rhode Island. All cash payments must be made at the Bursar's Office only. Registration in any course or activity (credit or non-credit) will NOT take place unless all monetary obligations to the College are fulfilled.

Students will receive an email notification confirming their registration within 2 days if a legible, valid email address is provided on this form. If you do not receive notification, you can call one of our offices to confirm your registration. It is necessary for you to provide all required information, except those fields noted as 'optional.'

Refund Policy: Students must provide a minimum of 48-hours' notice prior to the start of a course in order to be eligible for a refund. Without proper notice or documented medical excuse, students will be required to re-register and pay. No partial refunds of tuition are made under any circumstances. Books and materials may be non-refundable depending on the course. Students are eligible for a refund in full if the course has been cancelled by CCRI.

STUDENT SIGNATURE ____________________

FOR OFFICE USE ONLY:

I am paying by (Check One):

☐ Personal Check
☐ Money Order
☐ Charge

TOTAL PAID $ ______

*Please make checks or money orders payable to CCRI.

CHARGE CARD INFORMATION

☐ Discover ☐ MasterCard ☐ Visa

I WANT TO CHARGE MY FEES TO (Credit Card Account #:)

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

CREDIT CARD HOLDER

Print Name ____________

Exp. Date _____ / _____

3-Digit Security Code ______

Card Holder's Signature ____________

Hospital-based Massage Training Program Admissions Check List

You will be required to provide the following before deadline start date of class:

_____ A copy of your massage therapist license from the state of RI, CT, MA or other states

________ A copy of your current professional liability insurance

________ A copy of your current personal health insurance

________ A 300-500 word essay as to why you want to enter this program

________ Current resume

________ 3 letters of character references from members of the community (not from family members)

________ Proof of a minimum of 8 hours of Continuing Education

________ 2 years of massage therapy experience with clients (recommended, not required)

________ Must commit to the program's Massage Therapists Code of Ethics

_____ Hospital Health Requirements (Use the provided form)
_____ BCI

Continuing Education
A minimum of 8 hours is needed for acceptance. List all continuing education classes you have attended that are related to cancer, oncology, lymphatic drainage, compassionate touch or working with the frail client. If you have taken more classes, please continue on the back of this form.

Class and Instructor	Hours	Date Completed

Hospital-based Massage Therapy Training Program
Code of Ethics

Applicants for the program shall act in a manner that justifies public trust and confidence, enhances the reputation of the profession, and safeguards the interest of individual clients. Applicants of the program will:

I. Have a sincere commitment to provide the highest quality of care to those who seek their professional services.

II. Represent their qualifications honestly, including education and professional affiliations, and provide only those services that they are qualified to perform.

III. Accurately inform clients, other health care practitioners, and the public of the scope and limitations of their discipline.

IV. Acknowledge the limitations of and contraindications for massage and bodywork and refer clients to appropriate health professionals.

V. Provide treatment only where there is reasonable expectation that it will be advantageous to the client.

VI. Consistently maintain and improve professional knowledge and competence, striving for professional excellence through regular assessment of personal and professional strengths and weaknesses and through continued education training.

VII. Conduct their business and professional activities with honesty and integrity, and respect the inherent worth of all persons.

VIII. Refuse to unjustly discriminate against clients and/or health professionals.

IX. Safeguard the confidentiality of all client information, unless disclosure is requested by the client in writing, is medically necessary, is required by law, or necessary for the protection of the public.

X. Respect the client's right to treatment with informed and voluntary consent. The certified practitioner will obtain and record the informed consent of the client, or client's advocate, before providing treatment. This consent may be written or verbal.

XI. Respect the client's right to refuse, modify or terminate treatment regardless of prior consent given.

XII. Provide draping and treatment in a way that ensures the safety, comfort and privacy of the client.

XIII. Exercise the right to refuse to treat any person or part of the body for just and reasonable cause.

XIV. Refrain, under all circumstances, from initiating or engaging in any sexual conduct, sexual activities, or sexualizing behavior involving a client, even if the client attempts to sexualize the relationship unless a pre-existing relationship exists between an applicant or a practitioner and the client prior to the applicant or practitioner applying to the Program.

XV. Avoid any interest, activity or influence which might be in conflict with the practitioner's obligation to act in the best interests of the client or the profession.

XVI. Respect the client's boundaries with regard to privacy, disclosure, exposure, emotional expression, beliefs and the client's reasonable expectations of professional behavior. Practitioners will respect the client's autonomy.

XVII. Refuse any gifts or benefits that are intended to influence a referral, decision or treatment, or that are purely for personal gain and not for the good of the client.

XVIII. Follow this Code of Ethics, and all policies, procedures, guidelines, regulations, codes, and requirements of the Program.

I, ____, have read and understand the above Hospital-based Massage Therapy Training Program Code of Ethics. I agree to follow this Code of Ethics, and all policies, procedures, guidelines, regulations, codes, and requirements promulgated by the Program.

Student Signature: ____

Hospital Health Requirements

As we will be working in a hospital, there are important rules and regulations that each of us must understand. First and most important, is the hospital requires a health status report, **at least two weeks prior** to the arrival of a student at the hospital which demonstrates that the following immunization / Tuberculin Skin Testing requirements have been met prior to any on site work at the hospital. Please use the enclosed form.

Students must be in good health as determined, at a minimum, by the standards of immunization and communicable disease testing to ensure compliance in *Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers (R23-17-HCW)* as amended January 2007. This Includes:

Measles, Mumps, Rubella

- For students or instructors born on or before 12/31/1956 they will require 1 dose of Measles, Mumps and Rubella
- For students born after 01/01/1957 they require 2 doses of measles containing vaccine (preferably MMR), 2 doses of Mumps containing vaccine (preferably MMR) and 1 dose of Rubella containing vaccine. The first dose being administered on or after the 1st birthday and the second within 4 weeks. Or serological testing to prove immunity, regardless of date of birth.

Varicella

Two (2) doses of varicella vaccine. The second dose needing to be at least 4 weeks after first or proof of immunity by serological testing or healthcare provider diagnosis / verification of varicella or herpes zoster.

TdAP (Tetanus, Diptheria, Pertusis)

Students / Instructors under the age of 65 having their last Tetanus Diphtheria shot greater than 2 years ago require 1 dose of TdAP

Tuberculosis

Evidence student / instructor is free of Tuberculosis based on a negative 2-step Tuberculin Skin Testing (PPD) or a negative chest x-ray after most recent positive TST.

Hepatitis B Vaccine

Proof of appropriate immunizations; 3 shots: #1 followed by #2 in one month, 3rd at least 6 months from #1 or lab test confirming immunity

Influenza

Proof of vaccination in accordance with recommendations and requirements from the Dept. of Health and the Centers for Disease Control (CDC).

It may take some time to gather the necessary documentation, so please plan accordingly. As you can see, some shots require a month between, and others up to six months. Start on this early, so you have the time needed. If you lack any of these immunizations, it is up to you to schedule the necessary appointments with your primary care physician. You are financially responsible for meeting this requirement. This is required by the hospital and for your protection. If you are unable to meet this requirement, you will NOT be able to participate in this program. There are no exceptions.

Other Requirements

A Bureau of Criminal Identification (BCI) from the RI Attorney General's Office is required - 150 South Main Street, Providence. Upon presentation of your driver's license or a picture identification that includes your birth date, your BCI can be completed in moments for a $5.00 fee, payable by check or money order.

We will also send you information regarding compliance with their rules of conduct, behavior and protocol. Each site has an orientation and test for students to review and pass, in order to verify that they have read and understand their guidelines. If for any reason, you do not pass, you will NOT be allowed to continue in this program. There are no exceptions.

Immunization Form for Hospital-based Massage Therapy Students

In accordance with the Rhode Island Department of Health's Rules and Regulations Pertaining to Immunization, Testing, and Health Screening for Health Care Workers **(R23-17-HCW),** students applying to the Hospital-based Massage Therapy Program must complete and return this form.

For details about immunization requirements, visit
https://www.ccri.edu/workforce/workforce/healthcare/MassageTherapyI.html

All students must complete part A and then have parts B and C completed and signed by a licensed health care provider.

- **NOTE: Titers are available through East Side Lab for a discounted rate. You must contact CCRI's Health Services nurse for a lab slip.**

Part A: Personal and Student Information

A Social Security number can also be used but a CCRI ID is preferred. Don't know your CCRI ID number? Contact us at (401) 333-7070.

Date: ____________________ CCRI ID: ________________________________

Student's name: ____ Date of birth: _____________________

Last First MI MM/DD/YY

Phone number: ____________________________ Email address: ____

Program location: ☐ Saint Anne's Hospital ☐ Roger Williams Medical Center

Part B: PPD and Color Blind Testing

Initial entry into program requires two negative PPD tests†, no less than two weeks apart and no more than six months apart. Then one test is required annually.

PPD Testing

Ist test: ___________ ______________

Planted Read ☐ Negative ☐ Positive Reading value_ mm

2nd test: ____________ ______________

Planted Read ☐ Negative ☐ Positive Reading value_ mm

†**Students with a history of positive PPD test MUST:**

- Provide proof of negative chest X-ray taken after an initial positive test result.
- Have a health care provider complete and submit the Tuberculosis Symptom Assessment form.

Part C: Immunization Information: Mandatory Titers (must attach lab work)

Measles/ Rubeola	Titer date:_ _______ ______ Immune ______Not immune	**Not immune: Vaccine required** Date vaccine: ______________	Re-titer 1-2 months:	Titer date:___________
Rubella	Titer date:_ _______ ______ Immune ______Not immune	**Not immune: Vaccine required** Date vaccine: ______________	Re-titer 1-2 months:	Titer date:___________
Mumps	Titer date:_ _______ _____ Immune ______Not immune	**Not immune: Vaccine required** Date vaccine: ____________	Re-titer 1-2 months:	Titer date:___________
Varicella (Chicken Pox)	Titer date:_ _______ _____ Immune ______Not immune	**Not immune: Vaccine required** Date: 1st vaccine_________ Date: 2nd vaccine_________	Re-titer 1-2 months:	Titer date:___________
Hepatitis B	**Skip to next block if you have already had the 3 doses** __________ 1st dose 2nd dose__________ *One month from first shot* 3rd dose ___________ *Six months from first shot* **Titer required in one to two months.**	Titer date:_________ *(only if you already have had 3 doses)* _____ Immune _____Not immune	Booster series required Date:_________ Date:_________ Date:_________	Re-titer 1-2 months: Titer date:_______________
Tdap	**Date:** ___________ Tdap replaces the Td for health care providers. Td = tetanus and diphtheria; Tdap = tetanus, diphtheria and pertussis. If your tetanus is older than two years, Tdap is required. Tdap is good for 10 years.			
Flu vaccine	**Strongly recommended (annually), not required; however, many clinical sites are requiring either proof of vaccination or signed medical exemption form.**			

Medical exam: I hereby certify that this student is in good health and able to participate in all clinical activities without limitations: **(Provider: Please initial.)**

Health care provider signature: ___________________________________**Date:**_________________

Provider printed name: ____ **Phone:** _________________

In an effort to ensure that all records are processed in a complete and efficient manner, we ask that all information be provided on this form ONLY, with any required lab results attached, and that they be submitted in a timely manner.

Note: Any student exempt from immunizations for medical or religious reasons must complete a certificate of exemption form, which is available through your physician's office. The completed form should be forwarded along with all other health information.