

**St David's Institute for Learning/ Austin Community College
PCT Boot Camp Registration Form**

The student completes this part of the form: Course Start Date: _____

Facility (Circle One): SDMC NAMC SAH RRMC Oakwood Bailey Square NASC Surgicare Georgetown

Student's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Contact Number: _____ Supervisor's Name: _____

Address: _____ City _____ Zip _____

Email: _____

PROGRAM DETAILS BELOW:

All classes are at ACC's Highland Business Center, 5930 Middle Fiskville Rd. from 0800-1630 in the Health Professions Institute on the 4th Floor

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Week 1	New Employee Orientation	Level I Skills	Level I Skills	Level I Skills	Level I Skills	OFF	OFF

Level I Skills:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> o Bedmaking o Feeding w/out swallowing problems o Hygiene—baths, oral care, shaving, etc. o Ambulation & transfer (w/out monitoring) o Basic Infection Control o Positioning o Basic Communication Skills/Basic Medical Terminology | <ul style="list-style-type: none"> o Applying TED hose o Assist w/elimination and perineal care o Restraints o Weighing patients o Active and Passive ROM o Vital signs o Intake/Output |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Week 2	Level I Skills	Level II Skills	Level II Skills	Level II Skills	Exam/Skills Checkoff	OFF	OFF
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Level 2 Skills

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> o Problem Identification/Reporting o Application of Heat and Cold o Obtaining specimens-urine, stool, sputum o Oxygen monitoring equipment o Pre & post operative care o Glucose monitoring | <ul style="list-style-type: none"> o Hemocult/Gastrocult o Incentive Spirometry o NG tube removal o Advanced Communication skills o Oral suctioning |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

The director/manager completes this part of the form.

I certify that the aforementioned employee has the approval to attend the classes indicated above.

Manager/Director Name: _____ Phone: _____

Email: _____

Manager/Director Signature: _____ Date: _____

Total to be billed to the department: _____ Dept. Cost Center: _____

FAX THIS FORM TO THE INSTITUTE FOR LEARNING AT 544-0130

OFFICE USE ONLY: Clinical Educator with the Institute completes this part of the form.

Clinical Educator Signature: _____ Date: _____

Date Faxed: _____ Person Faxed: _____

This authorizes Austin Community College to bill:

St. David's Institute for Learning
Attention: Gail Acuna RN
7800 Shoal Creek Blvd. Ste 124S
Austin, TX. 78757