

***When printing the application, DO NOT print on both sides of the paper (front and back), print***

***on separate pages.***

# Mammography Registration Information Packet September 6 – October 3, 2025

**Asheboro Campus MAM-2100AX-89370** **Class: Sa Sept.6-13, 7:45am-6:00pm**

 **Sa Sept.20-27, 7:45am-5:00pm**

**Clinical: MTWTHF, Sept. 15-Oct. 3 various clinical sites**

## Mammography

This course is designed to provide the educational and clinical experience for post-primary practice in

Mammography. Core topics include the mammographer’s scope of practice, quality control testing, using the proper technique to position the breast and special procedures, digital mammography, and the Mammography Quality Standards Act (MQSA). Upon completion, students may be eligible to sit for the American Registry of Radiologic Technologist post-primary certification in Mammography.

# Application Deadline is August 12 at 3 pm. When August 12 falls on a Saturday or Sunday, the deadline for applications will be the following Monday at 3 pm.

* ***No application will be processed unless it is complete. Incomplete applications will not be returned.***

**Completed applications should be submitted to Janet Ingold in the Welcome Center at RCC.**

If you have any questions regarding the application process or to register for the course, please call Janet Ingold at 336-633-0171 or Debbie Adams at 336-328-1752

Randolph Community College

**Mammography Student Registration**

**DIRECTIONS:** Students, please review this document and initial beside EACH statement. At the end of the document, please print and sign your name. Once completed, return the entire packet and all supporting documents to Janet Ingold in the Welcome Center at 629 Industrial Park Ave. Asheboro, NC

**NOTICE: Prior to registration, ALL students must acknowledge the following information**

|  |  |
| --- | --- |
|  | Student Initial each line toacknowledge understanding of the requirement |
| **1. I am aware it is my responsibility to submit ALL required****documentation by May 8 or I will NOT be eligible for the course.** |  |
| **2. I am aware that I am responsible for paying ALL fees associated with this course.** |  |
| **3. I am aware Background Check and Drug Screens are REQUIRED and****there are fees associated with this process that I am responsible for.** |  |
| **4. I am aware of the course requirements, and I can meet ALL the necessary requirements and attend scheduled classes, labs, and clinical sessions. Due to FDA rules, students must attend 100% of the course.** |  |
| **5. I understand that I must have a computer, laptop, or tablet and a reliable internet connection to complete coursework. I will inform the****instructor if I need assistance.** |  |
| **6. I am aware that I must make copies of all original documents, and these copies will not be duplicated for me.** |  |
| **7. I understand that if I am unsuccessful in the course, I will not be eligible to take the ARRT (M) exam.** |  |
| **8. I understand my clinical rotation will be selected by the instructor for****me and I must attend as directed.** |  |

**Phase 1: Required Documentation Due on or before May 1 @ 3pm.**

1. Submit completed Mammography Program Application Packet
2. Submit a copy of your:
	1. Immunization records *(see attached page for vaccine information*).
	2. Current **American Heart Association BLS Provider Course** (CPR) card. Classes are available through Continuing Education at RCC.
	3. Proof of ARRT registration or letter from Radiography program stating eligibility to sit for the registry exam. (Actual ARRT (R) registration must be submitted prior to the clinical portion of the course).
	4. One professional letter of recommendation.

## Completed applications should be submitted to Janet Ingold in the Welcome Center at RCC.

Printed Student Name:

Student Signature: Date:

Approved by: Date:

Randolph Community College Mammography Application

ALL INFORMATION ON THIS FORM IS HELD CONFIDENTIAL

*Registration is subject to class availability. Students must register with their legal name on all documents. Names must match exactly.*

(PRINT)

Last Name: First Name: Middle Name:

Maiden Name: Birth Date:

Mailing Address: City: State: Zip:

Home #: Cell: Email:

**Education**

**:** Associate Degree or Higher, please list:

School attended: United States Citizen?  Yes No Place of birth: State of Legal Residency:

**In case of Emergency contact:**

Name: Relationship: Phone:

**Registration Information**

* **Student Background Check and Drug Screening must NOT be obtained before starting the course**. Students will be provided information regarding completion of background checks and drug screening via email after the registration deadline.
* **Tuition is due at the time of registration**. Scholarships may be available. See the attached program information sheets for all fees associated with the corresponding program. Contact Janet at 336-633-0171 for more information.

*Students seeking accommodations due to a documented disability should contact Tammy Cheek at 336-633-0246 or email* *twcheek@randolph.edu.*

**Document Policy:** Copies of educational and identification documents are filed in RCC’s archives and are not returned to the students.

**Please do not give us your original or your only copy.**

**Attendance Policy**: Students in the Mammography program must be present for 100% of the course to pass the course due to FDA rules. No tardies or absences are allowed.

**Student Initials:**

**Refund Policy:** For a **full refund**, you must request your refund before class begins. For a **75% refund**, you must request your refund before the 5th class day. **No refunds are given after the 5th class day. Student Initials**

**By signing this document, I attest that the information given above is complete and accurate. I understand and agree to the program requirements and will abide by all RCC policies and regulations.**

Student Signature: Date:

# Randolph Community College

**Mammography**

*Classes will be held in the Robert S. Shackelford Allied Health Building and online in Moodle. Clinical portions of the course are at various locations and will be assigned by the instructor.*

Students are accepted on a first-come-first served basis.

Class sizes are limited. Reliable transportation is essential as you will be required to travel to your clinical location, which may be outside of Randolph County. Clinical externships will take place Monday through Friday, with schedules that may range anywhere between 5:00 am and 11:00 pm, depending on clinical site availability. The instructor will set the clinical schedule after the course begins.

**Costs:** (Students are responsible for all fees associated with the program and national exam)

## Paid at the time of registration:

* Registration: $180.00
* Supply fee: 30.00
* Student ID: 0.50
* Accident insurance: 0.55
* Liability insurance: 16.00

o Total: $227.05

## Paid separately:

* ARRT Exam Fee: $225.00
* Drug Screening- $40 (approximate) DO NOT complete until instructed to do so.
* Criminal Background $60 & up (depending on searches) DO NOT complete until instructed to do so.
* MQSA required training tomosynthesis test $130
* CPR Class- $75 (if needed)
* Scrubs- Any solid color scrubs may be worn to clinical. They must be well-fitting and in good condition.
* Textbook: Available for purchase from our campus store. Pricing is available in the campus store or online at <https://bookstore.randolph.edu/>

**RANDOLPH COMMUNITY COLLEGE**

**629 INDUSTRIAL PARK AVE., ASHEBORO NC 27205/**[**www.randolph.edu**](http://www.randolph.edu/) **CONTINUING EDUCATION STUDENT REGISTRATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| NAME (Please Print)Last | First | Middle | Maiden |
| Street Address or Post Office | City | State | Zip | County |
| Home Phone # | Work Phone # | Cell Phone # | Social Security Number or your 7-digit Student ID Number |
| E-mail Address: |
| Date of Birth | Employment Status – Circle OneE1 - Employed 1-10 Hrs. E4 - Employed 40 or more Hrs US - Unemployed Seeking E2 - Employed 11-20 Hrs. R - RetiredE3 - Employed 21-39 Hrs. UN - Unemployed – Not SeekingName of Employer:  |
|  - -  |
| If 65 or older, Check here |
| Ethnic – Circle One Race – Circle One | Gender – Circle One |
| 1. Non-Hispanic/Latino 1. American/Alaskan Native 4. Hawaiian/Pacific Island | M - Male |
| 1. Hispanic/Latino 2. Asian 5. White
2. Black or African American
 | F - Female |
| Circle highest grade completed or check if passed High School (HS) Equivalency (GED) 1 2 3 4 5 6 7 8 9 10 11 12 13-Adult HS Diploma14- One Year Vocational Diploma 15-Associate’s Degree 16-Bachelor’s Degree 17-Master’s Degree or higher |
| How did you learn about the class? |
|  |
| **Section Number**Ex: CAS3020A 98000 | **Section Title**Introduction to Computers | **Day(s)**T, Th | **Time**6-9 pm | **Fees**$125 | **Location**Main Campus |
|  |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |

Please check one:

I certify that I am at least 18 years old or that I am under 18 and have provided a Minor Release Form to the Continuing Education Registration Office. .

Signature Date Amount Paid For CE Registration Only

Method of Payment: Cash Check Credit Card - (circle one) MASTERCARD VISA Revised 9/21/21 kwt

# Randolph Community College

**Mammography Program** **Performance Standards & Guidelines**

## Guidelines for Evaluation of Physical Health

Physical health is defined as being free of disabling or contagious diseases, being able to perform fine and gross motor skills, and being able to perform normal weight-bearing activities. Ongoing assessment of physical health is based upon instructor observation during the course. If a physical health problem threatens to prevent or prevents satisfactory classroom or clinical performance the student is referred to an appropriate professional. The recommendation of the professional is utilized to advise the student regarding admission or continued enrollment. Applicants or students may be denied admission or continued enrollment until the identified problem is satisfactorily corrected to the satisfaction of the course instructor.

## Guidelines for Evaluation of Emotional Health

Emotional health is defined as reacting appropriately to stressful situations, coping with everyday stressors

effectively, using healthy coping mechanisms, and understanding one’s own ability to cope with stressful situations. Ongoing assessment of emotional health is based upon instructor observation during the course. If an emotional health problem threatens to prevent or prevents satisfactory classroom or clinical performance, the applicant or student is referred to an appropriate professional. The recommendation of the professional will be utilized to determine whether admission or continued enrollment in the program is appropriate. Applicants or students may be denied admission or continued enrollment until the identified problem is satisfactorily corrected to the satisfaction of the course instructor.

## ATTENDANCE

The Mammography Program’s attendance policy is very strict for class, lab, and clinical. Attendance plays a critical role in your success in the course. Satisfactory progress is difficult without regular attendance. If you are more than 10 minutes late you will be counted absent.

\*Please note that clinical externship days/times and locations may vary from your class/lab schedule. You will need to have a flexible schedule and reliable transportation.

**STUDENTS MUST ATTEND ALL CLASS/CLINICAL HOURS TO REMAIN IN THE PROGRAM**

**Technical Standards for Mammography**

Our program technical standards have been developed to help students understand nonacademic standards, skills, and performance requirements expected of a student in order to complete the curriculum. If an accommodation is necessary to participate in the program, it is imperative to identify a reasonable accommodation to those students who qualify under the Americans with Disabilities Act (ADA). Reasonableness is determined by RCC’s Student Services on a case-by-case basis utilizing the program technical standards. The accommodation needs to be in place prior to the start of the program, or it may delay your ability to start the program. It is the student’s responsibility to contact Tammy Cheek at336-633-0246 or email twcheek@randolph.edu. and request accommodations.

|  |  |  |
| --- | --- | --- |
| **SKILLS** | **DESCRIPTION** | **SPECIFIC EXAMPLES** |
| **MOTOR SKILLS** | Fine and coarse motor skills | Can stand, bend, tie, open containers, sit, push and pull equipment and furniture, lift from 10 to 50lbs., perform CPR, assist patients with ADL, monitor vital signs, do dressing changes, oxygen therapy, catheterization, tube feedings, ostomy care. |
| SMELL | Adequate sense of smell | * Able to smell smoke, offensive and non-offensive odors, such as fecal and urine smells or perfume.
* Can smell and recognize infectious odors.
 |
| VISION | Near and Distant vision with or without corrective lenses | Can read regular sized print, discern skin colors, discern colors of equipment, shapes and sizes of injuries or lesions, determine distances such as 2 inches, 3 cm, 10 ft., 20 ft. |
| HEARING | No more than mild hearing loss with or without hearing aids | * Auditory ability must be sufficient to communicate/understand and give directions effectively to patients, family, and staff.
* Can hear alarms from beds and monitors, patient calls, call bells, persons speaking from across the room
 |
| TECHNOLOGICAL | Ability to collect, interpret, and integrate information and make good decisions within range of abilities and scope of practice.Can operate acomputer, small equipment | Can operate equipment such as Sequential Compression Devices, warming blankets, Dynamaps (vital sign monitors), oxygen therapy, tube feeding machines, CD player, use email, basic computer programs such as Excel, Word, can upload and download information, FAX |
| COMMUNICATION | Able to effectively express oneself in English in verbal, nonverbal, and written formats with faculty, students, patients, and families, and other healthcare team members.Ability to speak coherently and appropriately | Spoken, written and electronic language is clearly understood by staff, patients, and families. Communicate effectively and sensitively, both orally and in writing, with all members of the healthcare team and/or patients. Read and comprehend written material such as textbooks, test materials, procedure manuals, instrument manuals, and safety/personnel policies. Transmit information clearly, accurately, and efficiently. Create organized, legible, and coherent written documentation |
| CRITICAL THINKING/ PROBLEM SOLVING | Ability to collect, interpret, and integrate information and make good decisions within range of abilities and scope of practice. Can detect abnormal or untowardsituations and act or report to superiors | Collect data, prioritize needs and tasks, and anticipate reactions. Transfer knowledge from one situation to another. Ability to exercise independently, ethical judgment and think logically in performing duties.Can intervene using job skills/knowledge related to training/position and reports in a timely manner to superiors. |

|  |  |  |
| --- | --- | --- |
| **SKILLS** | **DESCRIPTION** | **SPECIFIC EXAMPLES** |
| MOBILITY/MOTOR SKILLS | Mobility/Motor Skills | * Perform moderately taxing continuous physical work, including prolonged standing.
* Be able to access patients in beds, seated in chairs, and phlebotomy collection stations.
* Reach and bend to access laboratory benchtops and shelves easily and without restriction.
* Assist patients in and out of phlebotomy collection stations.
* Sufficient physical endurance to perform prolonged walking, sitting, and standing periods.
* Lift and move objects of at least 25 pounds.
* Demonstrate full manual dexterity of the body ergonomically.
* Maintain balance in multiple positions.
* Administer CPR.
* Position and maneuver while providing services, including bending and stretching.
* Perform repetitive tasks for 4-6 hours at a time.
* Perform skills at varying heights.
* Ability to perform manual laboratory procedures with dexterity.
* Ability to operate sensitive laboratory equipment, including computers, touch screens, and keyboards.
 |
| INTERPERSONAL SKILLS | Ability to effectively communicate and collaborate with faculty, student-peers in the classroom/lab/clinical settings, employers/healthcare workers, and when working with patients. Tries to foster positive relationships withpatients and staff | * Establishes collegial relationships with co-workers and rapport with patients, able to maintain emotional stability in negative situations remains calm and objective in crises, accepts accountability for own actions, establishes rapport with patients of diverse cultures and age groups, is respectful, empathetic, and team oriented.
* Observes HIPPA regulations consistently.
* Maintains a negative background check and drug screen.
 |
| ENVIRONMENTAL TOLERANCE | Can work in a less than optimal environment | * Could function in case of a fire or evacuation, with or without heat, or in case of flooding.
* Ensures that infection prevention protocol prevails concerning bodily secretions, hand hygiene, odor control, and exposure to infectious persons. Protects self and patients by using personal protective equipment as applicable.
* Can identify unsafe circumstances and assist in transfer or evacuation of patients.
 |

*This document is intended to serve as a guide regarding the physical, emotional, intellectual and psychosocial expectations placed on a student. This document cannot include every conceivable action, task, ability or behavior that may be expected of a student. Meeting these technical standards does not guarantee employment in this field upon course completion. Ability to meet the program’s technical standards does not guarantee a student’s eligibility for any licensure, certification exam, or successful completion of the program.*

# Randolph Community College

**Mammography Program** **Criminal Background and Drug Screening**

Information Regarding Criminal Background Check/Drug Screen for Clinical Externships

Affiliating clinical agencies require a national criminal background check and drug screen as a prerequisite for clinical learning experiences. The clinical agency will review background checks and drug screening results. Positive results can result in a clinical agency denying students access to clinical practice in the facility. Any student denied access to any clinical facility will not be allowed to progress in the course. Students are responsible for all fees associated with background checks/drug screens.

Drug Screening - approximately $45.00

Criminal Background Check - $60.00 & up - depending on searches

## Do NOT obtain a background check or drug screening while completing the application portion. Instructions will be provided via email after the registration deadline has passed.

You are signing this form as an acknowledgment of this requirement.

My signature below indicates that I am aware of the information regarding the national criminal background check and drug screen being required. I understand that if I fail to meet certain criteria, as set by the clinical facilities, I may not be able to participate in clinical education and that this may prevent my successful completion of the course/program to which I am applying.

Signature:

Print Name:

Date: Student ID#

**IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit. Please review the information noted in each section before entering information.**

**All written information for immunizations must be supported by documents (i.e. NCIR Registry, Titer Result from Laboratory Company, Employee Health Record (ONLY if received by Employer), Pediatrician Office, etc.).**

**Acceptable Records of Your Immunizations May be Obtained from Any of the Following:** (Be certain that your name and date of birth are on each record. The records must be in black ink and the dates of vaccine administration must include the month, day, and year.

* High School/Previous College/University Records – These may contain some, but not all your immunization information. Contact Student Services for help if needed. **Your immunization records do not transfer automatically. You must request a copy.**
* Personal Shot Records – Must be verified by a doctor’s signature or by a clinic or health department stamp,

including a printout from any Immunizations Registry.

* Military Records or WHO (World Health Organization Documents).
* Employee Health records are not sufficient unless you received the required immunization from the facility and it is appropriately documented on the submitted document.

|  |  |  |
| --- | --- | --- |
| **Item to Complete:** | **How to Complete It:** | Completed and Documented: |
| MMR | 2 vaccines or positive titer\* | **□** |
| Varicella (Chicken Pox) | 2 vaccines or positive titer\* (history of the disease is**NOT** sufficient proof of immunity) | **□** |
| Hepatitis B\*\*\* | 3 vaccines, 2 dose series of Hep-B (Adult series), OR positive titer\* | **□** |
| TB Skin Test \*\* | Complete:1. QuantiFERON® TB Gold In-Tube test (QFT- GIT) or T-SPOT® TB test **(Radiography, Nursing, Medical Assisting)**
2. Screening with a 2-Step TST within 12 months of starting the program, must be administered 1-3 weeks apart with one 60 days within start of program, or 2 consecutive annual tests administered 10 to 12 months apart, with the most recent administered within the past 12 months **(Medical Assisting)**
3. See Notes below regarding positive screening
 | **□** |
| Tdap | Within 10 years (TD is **NOT** acceptable; must include pertussis) | **□** |
| Flu Shot\*\*\* | Given only during flu season; nothing to upload until flu vaccine for most current flu season |  |
| Covid\*\*\* | 1 vaccine or 2 vaccines based on manufacturer, for someprograms. | **□** |

\*If a titer is submitted, a laboratory report must be attached. The healthcare provider should document positive or negative immunity.

***\*\****If a student has had a positive TB skin test in the past, such as due to TB exposure/infection or receiving the BCG vaccine, a chest x-ray will be required along with the Baseline Individual TB Risk Assessment (Baseline Individual TB Risk Assessment Form ([https://www.cdc.gov/tb/topic/infectioncontrol/pdf/health](https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf) [CareSettings-assessment.pdf](https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf))) and TB symptom evaluation. (Note: If a PPD is positive, chest X-ray should be negative for TB disease; X-ray should be no older than 1 year and the individual asymptomatic for TB).

\*\*\*Student exemptions/declinations may be allowed per agency discretion. Program requirements may differ due to clinical agency requirements.

Student Name: Date of Birth:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Measles, Mumps, Rubella (MMR)** | 2 doses of MMR | MMR Dose 1 / / MM DD YY | MMR Dose 2 / / MM DD YY |  |
| **OR** |
| Blood test titer confirming immunity (results of titer must be documented by provider) | Measles Titer / / MM DD YYTiter Result | Mumps Titer / / MM DD YYTiter Result | Rubella Titer / / MM DD YYTiter Result |  |
|  |
| **Hepatitis B** | 3 doses of Hepatitis B Vaccination, OR 2 doses as adultseries | Hep B Dose 1 / / MM DD YY | Hep B Dose 2 / / MM DD YY | Hep B Dose 3 / / MM DD YY |  |
| **OR** |
| Blood test titer confirming immunity (results of titer must be documented by provider) | Hep B Titer / / MM DD YYTiter Result |  |
|  |
| **Varicella** | 2 doses of Varicella Vaccine | Varicella Dose 1 / / MM DD YY | Varicella Dose 2 / / MM DD YY |  |
| **OR** |
| Blood test titer confirming immunity (results of titer must be documented by provider) | Varicella Titer / / MM DD YYTiter Result |  |
|  |
| **Tdap** (tetanus, diphtheria, and pertussis | Tdap Dose/ /  | Please specify vaccine type such as Boostrix or Adacel |  |
| MM DD YY |  |  |

Student Name: Date of Birth:

|  |  |  |  |
| --- | --- | --- | --- |
| **Tuberculin Nursing and Radiography Requirement** | Blood Test Titer- QuantiFERON Gold/TB Spot | Blood Test Titer / / MM DD YYTiter Result | If positive results, submit:* A clear chest x-ray (report required) within the last year, AND proof of past positive testing.
 |
|  |  |  |  |
| **COVID** | Dose 1 / / MM DD YY | Dose 2 / / MM DD YY | Additional Dose / / MM DD YY | Please specify vaccine type such as Pfizer or Moderna |

**\*\*Supporting immunization documentation required such as copy of NC Immunization Registry or official vaccination record.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature of Physician/Medical Provider |  | Date |  |  | Practice Phone Number |
| Practice Name**PRACTICE STAMP HERE:** |  | Practice Street Address |  |  | Practice City/State/Zip Code |