901 West Park Ave St 201
Ocean, NJ 07712
(732) 695 – 1190
admissions@mcinj.edu

Admissions Checklist

Prospective Student:

Program: DMS CVS ST SPT **Cohort:** AM PM **Requested Start Date:**

Instructions: Please check off the applicable boxes on this checklist and email it to admissions@mcinj.edu, along with your admission forms/documents or bring it in person. **Note:** You may submit this checklist even if you have not yet gathered all required documents. Any outstanding documents may be submitted after your admissions interview.

ADMISSION FORMS

- Application for Enrollment
- Attestation of High School Diploma
- Photo & Marketing Consent Release Form
- Liability Waiver & Assumption of Risk Declaration
- MCINJ Admissions Disclosure Form
- Clinical Externship Questionnaire
- Clinical Externship Requirements
- Scanning Consent Form
- Student Medical History

REQUIRED DOCUMENTS

- High School Transcript or High School Diploma
- Current Resume
- Government-Issued Photo ID
- Social Security Card (present in person; ***(Do Not E-mail)***

REQUIRED DOCUMENTS for Surgical Technology

- Official College Transcript Confirming Degree Awarded

REQUIRED DOCUMENTS for Diagnostic Medical Sonography and Cardiovascular Technology

- Official College Transcript Confirming Minimum 40 College Credits Including
- Two English/Communication Course
  - Course #
  - Course #
- Two College Mathematics Course
  - Course #
  - Course #
- Medical Terminology
- Anatomy & Physiology I with Lab..... in Person On Line
- Anatomy & Physiology II with Lab..... in Person On Line
- Physics with Lab..... in Person On Line

ADDITIONAL REQUIREMENTS

- First Letter of Recommendation ***(DMS/CVT only)***
- Second Letter of Recommendation ***(DMS/CVT only)***
- Letter of Full Time Commitment, Time Management and Distance Driving (***DMS/CVT only)***
- Social Security Card presented in person; ***(Do Not E-mail)***
- Financial Aid – Verification of secured program funding

Final Coursework must be documented by the ***Official Transcripts*** *from each college attended.*

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Application for Enrollment

All prospective students are required to complete this form as part of the admissions process. Completion of this application does not guarantee acceptance into the selected program. MCI does not discriminate on the basis of gender, handicap, race, color, creed, age, marital status, national or ethnic origin.

Program of Interest: DMS CVS ST SPT MA
Program Schedule*: Day (Monday – Thursday 8:30AM – 2:00 PM) Evening (Monday – Thursday 4:30PM – 9:30PM)

Clinical placement is at any affiliated site in New Jersey. The schedule may include weekends, evenings and holidays.

Last Name: _____ **First Name** _____ **M.I** ___ **DOB:** _____ **SS#** _____-____-_____

Home Address: _____ **Apt #**_____

City: _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____

The data below is required by the U.S. Department of Education

Race and Ethnicity:

1. Are you Hispanic or Latino? Yes No
2. Select one or more of the following races:
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White

Citizenship: US Citizen Eligible Noncitizen Noncitizen

Gender: Male Female X

Marital Status: Single Married Separated Divorced

Are you currently employed? Yes No

If yes, are you working: Full-time Part-time

High-School/GED: _____ **Graduated:** Yes No

Trade School: _____ **Credits:** _____ **Graduated:** Yes No

College: _____ **Credits:** _____ **Graduated:** Yes No

Foreign Degree: _____ **Credits:** _____ **Graduated:** Yes No

First time at a Postsecondary School? Yes No

Healthcare Work Experience? Yes No _____

Current Employer: _____

Program Funding: Financial Aid (Pell Grants/Student Loans) Unemployment Grant GI Bill Self-Pay

Do you have any known allergies? Yes No If Yes: _____

Emergency Contact:

Name: _____ **Phone:** _____ **Relationship**: _____

By signing below, I hereby certify that the information provided is true and accurate to the best of my knowledge. I understand that the submission of any false information may result in a dismissal from the school. In addition, I understand that upon my enrollment, I have to abide by the policies and regulations of MCI.

Name **Signature** **Date**

Admissions Office Use Only

Program: DMS CVS ST SPT MA **Approved** **Provisional:**

Notes: _____

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Attestation of High School Diploma

Date: _____

I, _____, have applied for admission as a student at MCI Institute of NJ. I understand that one of the requirements for admission to MCI is graduation from High School or its equivalency.

I hereby certify that I have earned a:

High School Diploma ☐ GED ☐

_____
(Name of School)

_____ _____ _____
(City) *(State)* *(Year of Graduation)*

Student must provide Official Transcripts for Highschool

Acknowledgment of Valid High School Graduation or GED Requirement

I understand that if proof of high school graduation or GED is found to be false or inaccurate, I will not have met the admission requirements for MCI Institute of NJ. As a result, I will be subject to immediate dismissal and may also be reported to the U.S. Department of Education.

_____ _____
(*Printed Name*) (*Student Signature*)

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Photo & Marketing Consent Release Form

Date: _____

I hereby grant MCI Institute of NJ permission to use any school photos taken of me, verbal testimonials, written testimonials, thank you cards, Facebook Reviews and Google Reviews in any and all of its publications, including website entries, without payment or any other consideration for marketing and advertising purposes. I understand and agree that these materials will become the property of MCI and will not be returned.

I hereby irrevocably authorize MCI to edit, alter, copy, exhibit, publish or distribute these materials for purposes of publicizing MCI's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to these materials.

I hereby hold harmless and release and forever discharge MCI from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____

(*Printed Name)* (*Student Signature)*

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Liability Waiver & Assumption of Risk Declaration

I _____, in consideration for my participation in many different clinical laboratory activities (potentially including phlebotomy and/or injections) at MCI Institute of NJ and/or clinical externship sites, hereby RELEASE, WAIVE, AND HOLD HARMLESS, MCI Institute of NJ, its affiliated clinical externship sites, faculty, staff, and students from any and all liabilities, claims, demands, action and causes of action whatsoever arising out of, or related to any loss, damage, or injury that may be sustained by me, while participating in such clinical activities.

I hereby also elect to voluntarily participate in clinical trainings, and to enter the above-named premises and engage in such activities knowing that certain risks of harm are, or may be inherent in the various actions, contemplated herein and that the activities may be hazardous to me:

- Examine and be examined by other students and/or instructors during clinical laboratory exercises such as phlebotomy, electrocardiograms, vitals, sonography scanning and others procedures required by the curriculum
- Exposure to sharp objects and instruments including needles, scalpels and chemicals.
- Lifting equipment up to 50 lbs.
- Moving heavy equipment on wheels (up to approx. 500 lbs.)
- Bend, stoop, push and pull routinely
- Work standing on feet 80% of the time

BY SIGNING THIS RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing Liability Waiver and Assumption of Risk Declaration, understand it, and sign it voluntarily as my own free act and deed; and that, no oral representations, statements, or inducements, apart from the forgoing written agreement have been made; and that I execute the release for full, adequate and complete consideration.

I represent that:

1. I am 18 years of age or older.
2. I understand and agree that I will participate in all curriculum required clinical lab activities.
3. I have no physical or emotional problems, nor any history thereof, which will impair my ability to utilize the Clinical Facilities at Medical Career Institute and its services in a safe manner.
4. My physical health is sufficient that I can meet the demands of my educational training.

_____	_____	_____
(*Printed Name)*	(*Student Signature)*	*(Date)*

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MCINJ Admissions Disclosure Form

Student Name: _____Program_____

The programs offered at MCINJ are accelerated, combining theory knowledge, lab training, and clinical exposure to help students achieve success in their chosen field. Our mission is to provide all necessary resources and guidance to help you reach your educational and career goals. However, your commitment, focus, and personal effort are essential to your success.

Important Disclosures

1. **No Guarantee of Job Placement:**
   The healthcare fields are competitive. It is essential for students to be determined, focused, and proactive in taking steps necessary to secure employment and achieve certification. MCI cannot guarantee job placement after graduation. We will provide you with the knowledge, skills and career guidance, but landing your first job also depends on your own preparation, effort and determination. Keep in mind that it may take **six months** or longer to secure a position, and your first opportunities may be per-diem, temporary, or contract roles. Along with your skills, employers also look at things like professionalism, communication, and interview skills — all of which can make a big difference in landing a job.

2. **No Guarantee of Credentialing Exam Success:**
   MCINJ does not guarantee successful passing of credentialing exams. We offer resources, training, and support to help you prepare; however, your performance on exams will depend on your study habits, dedication, and personal preparation.

3. **Personal Responsibility and Commitment:**
   While MCI provides resources and support, it is ultimately your responsibility to remain dedicated, focused, and actively engaged in your training, job search, and preparation for credentialing exams. To be successful, you must develop good study habits, effective time management skills, and ensure that other personal obligations do not interfere with your ability to dedicate 100% focus on the rigor of the program.

Student Acknowledgment

I, _____, acknowledge that I have read and understand the above statements. I accept that it is my responsibility to apply the knowledge and skills learned during my program to achieve success in my professional career.

Student Signature: _____Date: _____

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Clinical Externship Questionnaire

1. **Do you have active health insurance coverage?** ☐ Yes ☐ No
   If yes, please submit a copy of your health insurance card

2. **Are you currently employed?** ☐ Yes ☐ No

3. **What is your work schedule?** _____

4. **Is your work schedule flexible?** ☐ Yes ☐ No

5. **Do you have a valid driver's license and reliable transportation?** ☐ Yes ☐ No

6. **How will you commute to School and Clinical** _____
   (i.e. family, friend, uber, bus, etc)

7. **Do you have any upcoming planned vacations?** ☐ Yes ☐ No
   (i.e. Weddings, Family Trips, Etc.)

   _____
   If yes, please list the dates of vacations and/or holidays.

8. What is your primary language? (i.e. speaking, writing, reading)

   English_____ ☐
   Other _____ ☐

1. **Please check off the statement that best describes your computer level skill:**

Level 1	I do not use a computer; I only use my cell phone	☐
Level 2	I can use the computer to run a few specific programs such as checking e-mails or browsing the web	☐
Level 3	I can use the computer to run general programs, check e-mails, browse the web, use Microsoft Office and most of the operating system tools	☐
Level 4	I can use the computer to run all program, use most of the operating system tools and feel confident enough to teach others some basic operations	☐

By signing below, I attest that the above information is accurate to the best of my knowledge.

_____ _____ _____

(Printed Name) *(Student Signature)* *(Date)*

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Clinical Externship Requirements

I, _____, understand that by selecting to enroll into MCI, I must be aware of the clinical externship process, requirements and expectations. I must be aware of the clinical placement, travel times and schedules that may be selected for me.

Clinical Placement	Placement is at any affiliated clinical facility in New Jersey. MCI does not guarantee or promise any clinical site to students.	_____ **Initials**
Travel Time	Students may be required to travel up to 2 hours one way for clinicals. MCI does not place students at the closest facility to their residency.	_____ **Initials**
Schedule	Students clinical schedule may be Monday – Friday, Weekends, Evenings and on Holidays. Weekly schedule is 32-40 hours.	_____ **Initials**
Associated Fees	Students are expected to pay any fees associated with clinical placements such as driving expenses, tolls, parking fees, etc.	_____ **Initials**

I, _____, understand that prior to clinical placement, I must meet the following clinical clearance requirements. I also authorize for MCI to release my medical forms, background check results and drug screening results to the clinical externship site.

Medical Forms	Students will not be placed at a clinical site unless they submit the Medical Forms and all supporting documentation.	_____ **Initials**
Background/Drug Check	Students background check will be initiated by the school. Students must have a clear background check and/or drug test results.	_____ **Initials**
CPR Class	Students must attend a CPR class which is scheduled one day Monday-Thursday between 2:30 - 4:30 PM on-campus.	_____ **Initials**
Financial Aid Clearance	Students will not be placed at clinical site unless they have met all financial aid obligations with the Financial Aid Director.	_____ **Initials**

_____ _____ _____

(Printed Name) *(Student Signature)* *(Date)*

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Ultrasound Laboratory Scanning Consent/Liability Form

I understand that participating to be scanned in the *Diagnostic Medical Sonography* or *Cardiovascular Sonography* program is for teaching and/or demonstration purposes only and is completely voluntary. I understand that choosing not to volunteer will have no negative impacts.

- I understand that the program faculty will be assisting sonographic examinations for educational and demonstration purposes in order to improve comprehension of the course materials. I also understand that the nature of this type of examination may entail exposing and touching of the chest/breast, back, upper and lower abdomen, extremities, and neck areas.
- I understand the purpose of the ultrasound procedure is not to provide medical care or diagnose medical conditions. I recognize the possibility that pathology may be found. If noted, the instructor may inform me to contact my personal physician. I also recognize that because this scan is being performed for training purposes, there is a possibility that existing pathology may not be noted due to the focus of the lesson. I agree not to hold Medical Career Institute, the Diagnostic Medical Sonography or Cardiovascular Sonography program, its students or employees liable for any circumstances that may arise from any these actions.
- I understand the biological effects involved with ultrasound scanning. Ultrasound uses nonionizing energy and does not possess the effects found with ionizing energy such as radiation from x-rays. Although the possibility exists that biological effects may occur with scanning, the AIUM statement on clinical safety states that within the diagnostic imaging intensity levels, no harmful effects have been known to occur since its use for medical diagnoses in the 1960s on patients or its operators.
- I am submitting this release, waiver of liability, and assumption of risk declaration voluntarily and of my own free will. I hereby waive and release Medical Career Institute, its officers, agents, employees, clinical affiliates, and students from any claim alleged to result from injuries arising from or related to my participation as a model in the ultrasound laboratory.

VOLUNTEER CONSENT

I recognize that by participating in this activity, no medical care is being provided and that individuals scanning are learning skills and their interpretations of ultrasound imaging in either finding abnormal conditions, or not finding abnormal conditions, should not be considered factual and/or a medical diagnosis in any way. I understand that the ultrasound procedure performed on me is purely for educational purposes to teach learners the skills of conducting point of care ultrasound. The purpose of the ultrasound procedure is **not** to locate or diagnose medical conditions.

☐ I **agree** to volunteer as a model for ultrasound scan

☐ I **decline** to volunteer as a model for ultrasound scan

Participant Name: _____ Date: _____

Participant Signature: _____

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Student Medical History

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone Number: _____

Have you ever had the following? *(Please place check in box)*:

	YES	NO		YES	NO		YES	NO
Chicken Pox	☐	☐	High Blood Pressure	☐	☐	Known Allergies to Medications?	☐	☐
Diabetes	☐	☐	Tuberculosis	☐	☐	Known Allergies to Latex?	☐	☐
German Measles	☐	☐	Anemia	☐	☐	Known Allergies to Iodine?	☐	☐
Mumps	☐	☐	Epilepsy	☐	☐	Known Food Allergies?	☐	☐
Measles	☐	☐	Heart Disease	☐	☐			
Mononucleosis	☐	☐	Asthma	☐	☐			
Renal Disease	☐	☐	Scarlett Fever	☐	☐			
Hepatitis	☐	☐	Rheumatic Fever	☐	☐			

Do you have any physical restrictions requiring medical care? **YES** ☐ **NO** ☐
If "Yes," please provide clearance from your healthcare provide to participate in classes.

Are you taking any prescription medication on a regular basis? **YES** ☐ **NO** ☐
If "Yes," please note and be aware a positive drug test can be caused by a prescribed medication.

_____
_____

Do you have any known allergies? **YES** ☐ **NO** ☐
_____
_____

I, _____ hereby authorize my physician to release to Medical Career Institute, its appropriate employees and agents the requested medical information contained herein. Furthermore, I understand that clinical affiliating agencies may require copies of medical records including copies of prescriptions. I hereby authorize Medical Career Institute, its directors, officers, employees and agents, to release my records to the clinical affiliating agencies and/or any future employer.

_____ _____ _____
(*Printed Name*) (*Student Signature*) (*Date*)