

Barbara L. Nadeau
LPN Financial Aid Advisor
email: bnadeau@wswheboces.org
voice: 518/746-3508

2016-2017

Greetings Future LPN Student:

Thank you for your interest in the Washington Saratoga Warren Hamilton Essex BOCES Licensed Practical Nurse Program. The full-time, ten (10) month, accelerated program is offered September through June at the Southern Adirondack Education Center (SAEC) in Hudson Falls. For more information, please visit our website <http://www.wswheboces.org/lpn>.

Per your request, you will receive updated information regarding application and admission requirements, test dates, tuition, textbook and supply charges once they become available for the 2016-2017 LPN Program.

The *Licensed Practical Nurse (LPN) Steps for Enrollment and Admission* are attached/enclosed for your convenience.

Also attached/enclosed, please find the WSWHE BOCES LPN Application for Enrollment. All forms must be received to the Admissions Office before an interview with the Adult LPN Supervisor will be scheduled.

- Practical Nursing Student Enrollment/Information Application
- Essay – LPN Interest
- Learning Style Questionnaire
- Three (3) Professional Character References
- Student Medical History
- Physical Examination Form (To be completed by your physician)
- Immunization Status Record (**MMR & Hepatitis B Series 1-3 are Required**)
- PPD (TB) Test (**Required**)

Need money for college? You may apply for federal financial aid for the 2016-2017 school year as early as January 1, 2016 by filling out the Free Application for Federal Student Aid (FAFSA) at <http://www.fafsa.ed.gov/>. Please use the WSWHE BOCES **school code: 015204** when filling out your FAFSA. Please be advised there is **no charge** for filing a FAFSA. If you are being asked for a credit card number, you are on the **wrong** website. Exit that website immediately and log on to the website shown above.

Please contact Barbara L. Nadeau, Financial Aid Advisor, at 518/746-3508 or bnadeau@wswheboces.org with any additional questions.

Thank you, once again, for your interest in the Licensed Practical Nursing program at the WSWHE BOCES, Southern Adirondack Education Center (SAEC).

Attachments/Enclosures

The Washington-Saratoga-Warren-Hamilton-Essex BOCES doesn't discriminate in its employment and admission to programs and activities as applicable, on the basis of actual or perceived race, color, creed, sex, sexual orientation, national origin, religion, age, economic status, marital status, veterans' status, political affiliation, domestic victim status, use of a guide dog, hearing dog or service dog, disability, or other classifications protected under federal or state law, and provides equal access to the Boy Scouts and other designated youth groups. The designated district compliance officers will coordinate compliance with the nondiscrimination requirements of Title VI and Title VII of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, as amended, the Boy Scouts of America Equal Access Act, and the New York State Human Rights Law.

The BOCES Compliance Officers are: Donna J. Wisenburn, Director of Human Resource Services or Timothy G. Place, Deputy District Superintendent, Washington-Saratoga-Warren-Hamilton-Essex BOCES, 1153 Burgoyne Avenue, Suite 2, Fort Edward, NY 12828, phone (518) 581-3310 or 746-3310. Complaints may also be filed with the Office for Civil Rights, New York Office, U.S. Department of Education, 32 Old Slip, 26th Floor, New York, NY 10005-2500, phone (646) 428-3800, fax (646) 428-3843, email: OCR.NewYork@ed.gov



LICENSED PRACTICAL NURSE (LPN)
STEPS FOR ENROLLMENT AND ADMISSION

☐ **STEP 1 - Pre-Admission Testing: Available on Thursdays in March & April**

Students interested in applying to the LPN program must pass a TEAS (Test of Essential Academic Skills) Exam with a score of 55% or higher to be eligible for enrollment in the LPN program.

- Go directly to www.atitesting.com to view the test dates and times, register and make payment for your TEAS Exam.
- For pre-admission test preparation materials visit: www.atitesting.com. Choose: "Shop online for TEAS Study Manual and Online Practice Test." (Optional)
- All pre-admission TEAS testing will be held at the WSWHE BOCES, SAEC Campus, 1051 Dix Avenue, Hudson Falls, New York.

☐ **STEP 2 - Test Information:**

Test dates and times are located on the WSWHE BOCES website, www.wswheboces.org or on the ATI website, www.atitesting.com.

- **No Student will be admitted to the TEAS exam without a photo ID.**
- Arrive promptly.
- Allow 4 hours for TEAS exam and TEAS instructions.

☐ **STEP 3 - Getting Started:**

Applications must be received no later than April 30th.

- Complete enclosed/attached application.
- Include a **\$25.00 non-refundable application fee.** (Cash, check, money order, VISA, MC accepted).
- Please make checks payable to **"WSWHE BOCES."**
- Mail or drop off application and application fee to:

*LPN Financial Aid Office
Southern Adirondack Education Center
1051 Dix Avenue
Hudson Falls, NY 12839
Attn: Admissions*

☐ **STEP 4 - Transcripts:**

Transcripts must be received no later than April 30th.

High School Transcripts must be sent directly from your high school to the Financial Aid Office. Transcripts **will not** be accepted as “**official**” unless delivered via US mail. Please contact your High School Guidance Office and request to have your **Official High School Transcripts** sent directly to the LPN Admissions Office at SAEC (See page 1 for address).

- High School Transcript
- GED® or TASC™ (Test Assessing Secondary Completion)

☐ **STEP 5 - Additional Documentation Required:**

- Copy of Driver’s License
 - Copy of Social Security Card
 - CPR Certification (Infant, Child & Adult)
- Must provide current CPR Certification or must be CPR Certified before the start of school.

☐ **STEP 6 - References:**

References must be received no later than April 30th.

- Write your name on each reference form.
- Give each reference the Reference Form and a stamped envelope with the address below.

*LPN Financial Aid Office
Southern Adirondack Education Center
1051 Dix Avenue
Hudson Falls, NY 12839
Attn: Admissions*

- Select three people: Employers, supervisors, teachers, etc. These should be individuals who can speak to your ability to perform academically and skillfully. References from family members, friends or co-workers **will not be accepted. References letters will not be accepted unless they are delivered via US mail.** References submitted by applicant are invalid.

☐ **STEP 7 - Medical Documentation:**

Medical Documentation must be received no later than August 15th.

- Complete Student Medical History.
 - Physical Examination by a physician.
 - Complete Immunization Record
- Must include: MMR, Hepatitis B Series 1-3, PPD (TB)**

☐ **STEP 8 - Interviews:**

Interviews will be conducted during April and May.

- Scheduled after all the above steps are completed.
- Conducted at Southern Adirondack Education Center (SAEC).
- Prepare and dress as you would for an employment interview.
- Interview may include 1-4 members of the LPN program.

☐ **STEP 9 - Financial Aid:**

You will meet with the Financial Aid Advisor directly following your interview.

- The 1st meeting will include information regarding filing a FAFSA (Free Application for Federal Student Aid, Verification, applying for a student loan, how to complete your Master Promissory Note and Entrance Counseling on line and additional available funding options.
- Tuition, textbook, uniform and supply costs will be discussed.
- After you have been accepted to the LPN program, a 2nd meeting with the Financial Aid Advisor will be scheduled for July or August. At this time you will review your financial aid options, self-payment options and additional funding options. At this meeting you will sign the final entrance documentation including a payment contract with the WSWHE BOCES.

☐ **STEP 10 - Acceptance:**

Students accepted to the LPN program will be notified by June 30th.

- Once accepted to the LPN program, a \$100.00 **non-refundable fee** is required to reserve placement in the LPN program. Please submit payment to the address on page 1.
- Please purchase your textbooks and supplies no later than August 15th.

Contact Information:

• **LPN Financial Aid Office and LPN Admissions:**

- ❖ Barbara L. Nadeau - Financial Aid Advisor
- ❖ 518/746-3508 - bnadeau@wswehoboces.org

• **LPN Program Information:**

- ❖ Sheri Gordon – Adult LPN Supervisor
- ❖ 518/746-3504 – sgordon@wswehoboces.org

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Name: _____ <i>(Last)</i> <i>(First)</i> <i>(MI)</i>	Email Address: _____
Address: _____ _____	Home Telephone: _____
Other names used: _____	Work Telephone: _____
	Date of Birth: ____/____/____ MM DD YYYY

In case of emergency notify:

1.	_____	<i>(Name)</i>	<i>(Relationship)</i>	<i>(Telephone)</i>
2.	_____	<i>(Name)</i>	<i>(Relationship)</i>	<i>(Telephone)</i>

(High School Students ONLY)

Full name of both parents/guardians: _____

Home School Name: _____

Guidance Counselor: _____

RECORD OF EDUCATION:

School	Name & Address of School	Course of Study	Year Completed	Did you graduate	List Diploma or Degree
Elementary					
High School					
College					
Graduate					
Other					

Other training: (*i.e. typing, word processing, EMT, NA, HHA: Explain skills achieved*)

Sponsoring Agency (If applicable – One Stop Center, VA, Access)

Case Manager: _____ Phone Number: _____

Self Pay Option: _____

EMPLOYMENT (*Beginning with most recent position*)

Name and address of company:	From	To	List job title & description of duties:
Type of Business:			

Name and address of company:			List job title & description of duties:
Type of Business:			
Name and address of company:			List job title & description of duties:
Type of Business:			
Name and address of company:			List job title & description of duties:
Type of Business:			

1. What has made you choose this course of education to pursue? _____
2. What qualities do you feel you possess that qualify you for this program? _____
3. List any areas of education that you may need assistance with. Explain. _____
4. Is there anything in your health background that would prevent you from meeting the requirements of this program? _____
5. Have you ever been convicted of a crime? ____ Yes ____ No If yes, please explain. _____
6. Have you ever had a professional license suspended, revoked or ever been placed on probation? ____ Yes ____ No If yes, please state dates, reasons or restrictions. _____

I hereby certify that all statements I have made in connection with my application for education are true and that I have not withheld any information. I understand that if I am accepted into this program, any willful misrepresentation will be cause for dismissal.

(Signature)

(Date)

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Please return this form via e-mail to: bnadeau@wsweboces.org
 Or mail to: Southern Adirondack Education Center, 1051 Dix Ave, Hudson Falls, NY 12839 att:Admissions
 Or fax to: 518-746-3409



This essay must be submitted with a completed application packet before an interview will be scheduled. A typed response is strongly encouraged either on this form or a blank sheet. Please include your name and date on all documentation.

In 150 to 300 words, please explain why you are interested in becoming a Licensed Practical Nurse. Explain what inspired you to become a nurse. What are your future plans after becoming a LPN and what areas of nursing are you most interested in pursuing.

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Learning Style Questionnaire

Based on High School or Other Secondary Education Experiences

1. Are you able to read for up to two hours without interruption? Yes No
 Do you feel you have good recall from what you read? Yes No
 Can you do 'routine' math without a calculator? Yes No
 Do you 'generally' need further explanation for instructions
 on written tests? Yes No
 If yes, please explain _____
 Do you generally have difficulty following verbal directions? Yes No
 If yes, please explain _____

2. How do you rate your short term memory & your long term memory?
 Short Term Memory: _____ Long Term Memory: _____

3. Are you able to concentrate on tasks requiring many steps? Yes No
 Do you need a break after 15 minutes, 30 minutes or 45 minutes? _____
 What is an example of a task you do in your current life that requires concentration?

4. When you "study" for a test, what methods do you use to prepare?

Do you have anxiety when taking exams? If yes, how do you cope with test anxiety?

5. Are you able to use a computer:
 To type a term paper? Yes No
 To research a topic? Yes No
 To fill out a form? Yes No
 To e-mail? Yes No
 How do you rate your computer skills? Poor Fair Good

6. Have you used a computer, in any form, for employment? Yes No
If yes, please explain: _____
7. Do you **have** a computer at home? Yes No
8. Do you have internet access for your computer? Yes No
9. Will you require any “support” from the faculty to be successful in the academic portion of the program? Yes No
If yes, please explain: _____

10. How much time do you feel you can devote to study on a daily basis?

If you have ever had learning accommodations and/or feel you may need them to be successful in the LPN program, you will need to disclose and discuss them during the intake process. Your signature below indicates you have read and understand this statement.

Additional Comments:

Applicant’s Signature

Date

Please Print Name

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Practical Nursing program
Southern Adirondack Education Center
1051 Dix Ave, Bldg C
Hudson Falls, NY 12839

CHARACTER REFERENCE FORM

Applicant's Name: _____

The above named person has applied for admission to the Practical Nursing program at WSWHE BOCES.

Please provide the requested information regarding this applicant:

How long have you known the applicant? _____

What is your relationship to the applicant? _____

PLEASE RATE THE APPLICANT	Superior	Average	Poor
General Attitude			
Sense of Responsibility			
Personal Appearance & Hygiene			
Emotional Maturity			
Courtesy & Social Sense			
Discretion in Speech & Manner			

Why would you recommend/ not recommend this applicant for training as a Practical Nurse?

Signature

Date

Name: _____

Address: _____

Phone: _____



Practical Nursing program
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What is your relationship to the applicant? _____

PLEASE RATE THE APPLICANT		Superior	Average	Poor
General Attitude				
Sense of Responsibility				
Personal Appearance & Hygiene				
Emotional Maturity				
Courtesy & Social Sense				
Discretion in Speech & Manner				

Additional Comments:

Signature

Date

Name: _____

Address: _____

Phone: _____



Practical Nursing program
Southern Adirondack Education Center
1051 Dix Ave, Bldg C
Hudson Falls, NY 12839

CHARACTER REFERENCE FORM

Applicant's Name: _____

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What is your relationship to the applicant? _____

PLEASE RATE THE APPLICANT		Superior	Average	Poor
General Attitude				
Sense of Responsibility				
Personal Appearance & Hygiene				
Emotional Maturity				
Courtesy & Social Sense				
Discretion in Speech & Manner				

Additional Comments:

Signature

Date

Name: _____

Address: _____

Phone: _____

STUDENT MEDICAL HISTORY
 (To be completed by applicant)

Name: _____ Date of Birth: _____
 Sex (circle one) Male Female
 Address: _____
 Last time you were examined by a Doctor: _____
 Reason: _____

.....
 Date of last physical examination: _____
 Please list all symptoms:

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
- Routine check-up – no symptoms _____

Personal History:

Illness – Have you ever had: (circle answer)

Rheumatic fever or heart disease	No	Yes	Bladder or kidney disease	No	Yes
Any bone or joint disease	No	Yes	Epilepsy	No	Yes
Neuritis or Neuralgia	No	Yes	Tuberculosis	No	Yes
Bursitis, Sciatica or Lumbago	No	Yes	Diabetes	No	Yes
Polio or Meningitis	No	Yes	Cancer	No	Yes
Venereal Disease	No	Yes	High or Low Blood Pressure	No	Yes
Arthritis or Rheumatism	No	Yes	Hives or Eczema	No	Yes
Colitis or other bowel disease	No	Yes	Frequent infections or boils	No	Yes
Hemorrhoids or any rectal disease	No	Yes	Nervous breakdown	No	Yes
Anemia	No	Yes	Other diseases	No	Yes
Jaundice or liver disease	No	Yes	If yes, describe: _____		
Chicken Pox	No	Yes	_____		
Mumps	No	Yes	_____		

(Over)

Surgery: (circle answer)

Have you had any operations? No Yes
 If Yes:

Type _____ Year _____
 Type _____ Year _____
 Type _____ Year _____
 Type _____ Year _____

Have you ever been advised to have any surgical
 Operation which has not been done? No Yes

Give details: _____

Have you been hospitalized for any illness? No Yes
 Give details: _____

Injury: (circle answer)

1. Have you sustained any injury which has required Worker's Compensation? No Yes
 If so, please describe: _____
2. Do you have any physical limitations as a result of this injury? No Yes
 If so, please describe: _____

Do you have now or have you had: (circle answer)

Frequent or severe headaches	No	Yes	Recurrent nose bleeds	No	Yes
Fainting or unconscious spells	No	Yes	Shortness of breath	No	Yes
Blurred or double vision	No	Yes	Purple lips or fingers	No	Yes
Spots before eyes	No	Yes	Earaches or hearing problems	No	Yes
Any change in vision	No	Yes	Backaches	No	Yes
Infection or pain around eyes	No	Yes	Strange taste or loss in taste	No	Yes
Palpitations or fluttering of the heart	No	Yes	Strange persistent odors	No	Yes

I certify that the above information is true and correct to the best of my knowledge.

 Signature

 Date

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PHYSICAL EXAMINATION HEALTH FORM
(To be completed by physician)

IDENTIFICATION DATA:

P CO G<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa" F CVG'QH'DKTVJ <"aaaaaaaaaaaaaaaaaaaaa"
 "

CF FTGUU<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa" VGNGRJ QP G%"aaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

R'ECUG'QH'GO GTI GPE['ECNN<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

TGNCVQPUJ R<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaa" VGNGRJ QP G%"aaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

CF FTGUU<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 aaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"

PHYSICAL EXAM FORM:

J GK J V<"aaaaaa"Y GK J V<"aaaaaaa"V"aaaaaaa"R"aaaaaaa"Ta"aaaaaaa"DR"aaaaaaa"
 XKUQP <"

*Y kj qw'eqtte<vg"ngpugu+"Tki j v<"aaaaaaa"Ng"aaaaaaa"

*Y kj "eqttge<vg"ngpugu<"Tki j v<"aaaaaaa"Ng"aaaaaaa"
 "

J GCTR I <"Tki j v'gct<"aaaaaaa"Ng"v'gct<"aaaaaaa"J gctkpi "ckf <"aaaaa[gu"aaaaa'Pq"
 "

CP["UWTI GT["QT"UGTIQWU'KNP GUU<"aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa"
 "

"	"	"" NORMAL ""	"" ABNORMAL ""	COMMENTS:
"	"			
EYES"				
EARS"	"	"	"	"
NOSE"	"			
MOUTH & THROAT"				
NECK"				
HEART"				
LUNGS"				
BREASTS"				
ABDOMEN"				
BACK'REFLEXES				

IMMUNIZATION STATUS:

A. 1) *PPD Skin Test () Aplison () Tubersol **2 step required** for health programs providing direct care

#1 Date Given: _____ Date Read: _____ #2 Date Given _____ READ _____
Results: _____ Results: _____

2) For conversion (must have proof of following with in last 5 years).

Date of Conversion: _____ Clinical follow up: Yes ___ No ___ Where _____
Date of Chest X-Ray _____ Results _____

B. *Rubella Date of Vaccine _____ OR Date of Titer: _____ Results _____

*Rubeola Date of Vaccine _____ OR Date of Titer: _____ Results _____

Mumps Date of Vaccine _____ OR Date of Titer: _____ Results _____

C. MMR: Dose 1 - Date: _____

MMR: Dose 2 - Date: _____

D. Tetanus Date: _____ (current within 10 years)

E. Hepatitis B Vaccine :#1 _____ #2 _____ #3 _____

Positive Titer date _____ attach documentation

F. Varicella: Dose 1- Date _____ Dose 2- Date _____ Positive HX disease/**Titer** _____ -
attach documentation

G. Seasonal Flu: (last dose) _____

This is to certify that _____ is in good physical and mental health and is **free from any impairment which poses a potential risk to patients or personnel. He/She is physically able to perform his/her duties as a practitioner in clinical affiliations.**

Physician's Signature

Date

Print Name _____

Results of the History and Physical examination and immunization status will be retained at the school and will be available to New York State Department of Health, New York State Education Department, or Hospital Health Office should the need occur.

*PPD (Mantoux) skin test for the tuberculosis is required annually by New York State Department of Health as a condition of employment or affiliation. Positive findings shall require appropriate clinical follow-up, but no repeat skin test .A NEW HEALTH CARE PROVIDER MUST HAVE A TWO STEP PPD WITH ANNUAL UPDATES.

*Rubella proof of immunity by titer or documented vaccination is required by new York State Department of Health as a condition of employment or affiliation.

*ALL STUDENTS - Rubeola proof of immunity by titer or documented evidence of 2 doses of measles vaccine is required by New York State Department of Health as a condition of employment or affiliation.



Southern Adirondack Education Center

1051 Dix Avenue

Hudson Falls, NY 12839

<http://wsweboces.org>

voice: 518/746-3508

fax: 518/746-3409

STUDENT IMMUNIZATION RECORD

LPN PROGRAM

Student Name:	DOB:
Address:	Home Phone:
EMERGENCY CONTACT:	Phone Number:

Tuberculin Skin Test:

Date Given:	Date Read:	Result:
Date Given:	Date Read:	Result:
Conversion Date:	CXR Date:	Result:
Clinical follow up done:	Yes: location	No:

Rubella *	Positive titer/date:	Rubella Vaccine/date:	Rubella Vaccine/date:
Rubeola *	Positive Titer/Date:	Vaccine #1:	Vaccine#2
Varicella	History of chicken pox YES NO	Vaccine #1 #2	Positive titer/date:
Tetanus:	Date:		
Hepatitis B"	Date/#1	Date/#2	Date/#3
	Titer/Date:		
Hepatitis A"	Date/#1	Date/#2	

*Acceptable MMR Vaccines are those given after 1968

" optional

School Representative/Physician Signature: _____

On this form, a signature and stamp will only be accepted from the following: Physician, Physician Assistant, Nurse Practitioner or Registered Nurse.

Mantoux Tuberculin Skin Test

- ☐ If you have **never** had a PPD (TB) test **OR** if it has been **over 12 months** since receiving a negative PPD (TB) test:
 1. A baseline “Two-Step” Mantoux Test (PPD) is required for all new students regardless of prior BCG inoculation.
 2. After baseline testing, all health care students must have an annual Mantoux Test. If the interval between testing is greater than 364 days, the Two-Step will be repeated.
- ☐ If you have a documented **negative** PPD (TB) test **within 12 months** of entering the program:
 1. A “One-Step” is required **ONLY** if a negative Mantoux test result is documented within the previous 12 months. Date done and proof of this past testing is required. Prior “Two-Step” baseline testing will be accepted only if done no more than 3 months prior to enrollment.
 2. After baseline testing, all health care students must have an annual Mantoux Test. If the interval between testing is greater than 12 months, the Two-Step will be repeated.
- ☐ If you do **NOT** have documentation for a negative PPD (TB) test done within 12 months of entering the program:
 1. A repeat baseline “Two-Step” Mantoux Test (PPD) is required. There is no danger in having these tests repeated. This is if documentation is not available to you.
 2. After baseline testing, all health care students must have an annual Mantoux Test. If the interval between testing is greater than 12 months, the Two-Step will be repeated.
- ☐ If you have previously had a **positive** Mantoux (PPD) test:
 1. All new students with a previously **positive** Mantoux must provide the following documentation:
 - 1) The reported induration measured in mm and 2) one chest radiograph to exclude a diagnosis of TB disease. After this baseline chest radiograph is performed and the result is documented, repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph **OR** 3) have a BAMT (blood assay for M. tuberculosis). If the latter, proof of testing with a complete report which provides an interpretation of the test result and indicates the concentration of interferon-gamma. If the BAMT results are “inconclusive” or “positive”, a report of a negative chest x-ray is to be provided.
 2. Students with a **previously positive** Mantoux must have an annual symptom check and evaluation in the Student Health Office.

Mantoux Conversion

1. If a test result becomes positive (induration ≥ 10 mm) after previously being negative, neither student nor faculty can be on campus, attend class or attend clinical until a negative chest x-ray report is submitted and received to the WSWHE BOCES Health Office.
2. Medical evaluation for possible treatment of LTBI is recommended for those individuals with a known recent Mantoux conversion.