TRANSFER CHECK OFF LIST

TCU/IAM Advanced Training Program – Humphrey Job Corps Center

Student Name: _____

Student ID: _____ Date Sent: _____

Sending Center: _____ Receiving Center: _____

1. Please send the below information to the HUBERT H. HUMPHREY JOB CORPS CENTER via Job Corps Citrix email to: dreis.jason@jobcorps.org and reetz.lizzie@jobcorps.org. If emailing is not possible please mail double sided copies of the following to: Jason Dreis, TCU/IAM Advanced Training Program, 1480 North Snelling Avenue, Saint Paul, MN 55108.

    - ☐ Current Student Profile Report (ETA 6-40)
    - ☐ Job Corps Data Sheet (ETA 6-52)
    - ☐ Student Conduct Profile Report
    - ☐ Evaluation of Student Progress
    - ☐ All Case Notes
    - ☐ Copy of GED or HSD
    - ☐ Completed Student TAR Report
    - ☐ Recommendation letter from an instructor, counselor or the Center Director

2. Please fax the Medical Student Transfer Summary Checklist (below) directly to the Hubert Humphrey Job Corps Health and Wellness Department (fax: 651-641-1657); please be sure to use a cover sheet, Attn: Pam Rideout and send an email to rideout.pamela@jobcorps.org to alert her to the incoming fax. If it is preferred, the checklist may be mailed overnight in a sealed envelope along with the above documentation.

If ALL of the information is not received by the Hubert H. Humphrey Job Corps Center, the student's acceptance into the Humphrey TCU/IAM Advance Training Program will be delayed.

I certify that all of the above documents are enclosed:

_____ _____

Sending Center Staff Member Phone Number

Staff Contact Information *TCU/IAM Advanced Training Program – Humphrey Job Corps Center*	
Lizzie Reetz Field Educational Assistant reetz.lizzie@jobcorps.org 651-444-1881	Jason Dreis Lead Field Educational Representative dreis.jason@jobcorps.org 651-444-1819

MEDICAL -STUDENT TRANSFER SUMMARY CHECKLIST

Complete summary and forward to the receiving center at least 2 weeks prior to student arrival (refer to PRH-6: 6.4, R2(c)).

Trainee Name: _____ **DOB:** _____ **Age:** _____ **CIS ID#:** _____

Date of Entry: _____ **Transferring Center:** _____

Date of Transfer: _____ **Receiving Center:** _____

Insurance: _____

_____

Allergies: _____

_____

Medication and Dosage: _____

_____

Chronic Illness(es): _____

Upcoming appointments (if applicable): _____

_____

MEDICAL

Date of last Physical Exam: _____

Height: _____ **Weight:** _____ **BMI:** _____

Vision Exam: _____ ☐ Contacts ☐ Glasses **Color deficit:** ☐ Yes ☐ No

Hearing Exam: _____

Cleared for Full Program/Sports: ☐ Yes ☐ No **Date Cleared:** _____

Activity Restrictions: _____

Date of Last Td or Tdap: _____

Date of Last PPD: _____ ☐ Positive ☐ Negative **Last CXR:** _____

TB Treatment Received/completed: _____

Medical Summary: _____

_____

_____

_____

_____

_____

_____

_____

Center Physician Signature: _____ *Date:* _____

ORAL HEALTH

Dental Priority Classification: ☐ Priority 3 ☐ Priority 4

Last dental appointment within 1 month before transfer date: _____

Orthodontics: ☐ Yes ☐ No **If yes, date of last orthodontic visit:** _____

Address and telephone number of orthodontic office after student transfers: _____

_____

Dental Summary, including treatment needs: _____

_____

_____

_____

_____

_____

_____

_____

Center Dentist Signature: _____ *Date:* _____

TEAP

Entry Toxicology: ☐ Negative ☐ Positive **If positive, list drugs:** _____

Suspicion Testing Dates/Results: _____

Alcohol Incidents: _____

Attended TEAP Intervention Services? ☐ Yes ☐ No **Dates:** _____

TEAP Summary: _____

_____

_____

_____

_____

_____

_____

_____

TEAP Specialist Signature: _____ *Date:* _____

MENTAL HEALTH

Mental Health Diagnoses: _____

_____

_____

Last CMHC Appointment, if applicable: _____

Provide date(s) of leaves/MSWRs for mental health related reasons: _____

_____

Mental Health Summary: _____

_____

_____

CMHC Signature: _____ *Date:* _____

DISABILITY/ACCOMMODATIONS

Disability/Accommodations Summary: _____

Disability Coordinator Signature: _____ *Date:* _____

HWM Signature: _____ *Date:* _____

Center Director Signature: _____ *Date:* _____