TCU/IAM TRANSFER CHECK OFF SHEET—POTOMAC JCC

Student _____ Student ID No. _____

Sending Center _____ Receiving Center _____ Date Sent _____

PLEASE SEND ALL INFORMATION TO THE TCU/IAM POTOMAC JOB CORPS TRAINING PROGRAM AT ONE TIME BY OVERNIGHT MAIL.

The following information is required by the POTOMAC Job Corps Center prior to a student's transfer to TCU/IAM:

1. **Information needed – not sealed:**
   - ❒ Current Student Profile (ETA 6-40) updated with leave, accountability, incidents, ESPs, and pay levels
   - ❒ Data Sheet (ETA 6-52)
   - ❒ Copy of GED or High School diploma
   - ❒ Separation Advance Report
   - ❒ Copy of TAR cover sheet
   - ❒ Recommendation letter from an instructor, a counselor or the Center Director
   - ❒ Case Notes
   - ❒ Student Profile Conduct Report
2. **Medical Summary Checklist**

All of the above student material needs to be sent by overnight mail in one package to:
TCU/IAM Advanced Training Program, Ms. Jessica Witchoski, Lead Field Educational Representative, Potomac Job Corps Center, Building #2, #1 DC Village Lane, SW, Washington, DC 20032. Phone (202) 373-3118.

PLEASE MARK THE PACKAGE "PERSONAL AND CONFIDENTIAL."

I certify that all of the above documents are enclosed:

_____
Sending Center Staff Member

Date_____

Phone Number _____

08-16

STUDENT TRANSFER MEDICAL SUMMARY CHECKLIST

Complete summary and forward to the receiving center in a sealed envelope marked "confidential" along with this application packet.

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:*** _____

Update Immunizations: Done _____

Immunization record faxed to 512-396-6316: Done_____

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:*** _____