Center for Health Sciences
1070 Alton Way, Building 849
Campus Box 201
P.O. Box 173363
Denver, CO 80217
Fax: 303-365-8396
Phone: 303-365-8372
Email: lorriane.yost@ccd.edu
Website: https://www.ccd.edu/org/center-health-sciences-lowry

# MAMMOGRAPHY PROGRAM
# CHECKLIST OF CLINICAL PARTICIPATION REQUIREMENTS

First Name: _____ Last Name: _____

SID#: S_____ Phone: _____

Email: _____@student.cccs.edu

**Note:** Your official CCD email account is the only email CCD will accept for correspondence.

*I affirm that I have read, understand, and agree to this form in its entirety and that the information supplied is true and complete.*

Student Signature: _____ Date: _____

**You must have all clinical participation requirements completed and turned in.**

1. **Sign in and return the following:**
   - ☐ Program Application
2. **Copy of the following and return:**
   - ☐ Resume
   - ☐ Current AART Card
   - ☐ Current CPR Card (BLS Healthcare Provider by American Heart Assoc.)
   - ☐ Medical (Health) Insurance Card
   - ☐ Immigration paperwork (If not a United States Citizen you must be a legal immigrant
3. **Complete and Return**
   - ☐ Health & Immunization Form
4. **Background Check: (at instructors approval) *Note, you will be advised by the Program Coordinator when to complete these forms.**
   - ☐ Background Check
   - ☐ Drug Screening Process
5. **State of Colorado Provisional Mammography License Application**
   - ☐ This will be filled out in class

Lori Yost, Mammography Program coordinator; lorriane.yost@ccd.edu or 303-365-8372
Daniela Higgins, Health Sciences Coordinator; daniela.higgins@ccd.edu or 303-365-8378