

# **RESPIRATORY THERAPY DEPARTMENT**



# **CLINICAL APPLICATION PACKET**



**RESPIRATORY THERAPY DEPARTMENT  
STUDENT ADMISSION APPLICATION CHECKLIST**

---

**DIRECTIONS: Complete all parts of this application packet and return to:**

**Southern University at Shreveport  
Division of Allied Health  
Respiratory Therapy Department  
Attention: Mrs. Katrina Harris  
610 Texas Street, Suite 211  
Shreveport, LA 71101**

Read and follow all directions carefully. Check off each step as you complete it. You will be required to sign that you have read and understand all steps of the application process.

**All application information, transcripts and forms must be received by the Respiratory therapy Department Director of Clinical Education on or before May 11, 2018 by noon.**

- \_\_\_ 1. Completed pre-clinical orientation form. Please read clinical packet for further information.
- \_\_\_ 2. Submitted THREE (3) Recommendation Letters enclosed in this Packet, or have them sent to the Respiratory Therapy Department.
- \_\_\_ 3. Attach OFFICIAL TRANSCRIPT(S) from each former college or university.
- \_\_\_ 4. Complete the CANDIDATE APPLICATION FORM enclosed in this packet and return with all other documents by **May 11, 2018 by noon**.
- \_\_\_ 5. Submit a copy of ACT scores with the application packet.
- \_\_\_ 6. Submit a typed letter stating why you decided to pursue a career in Respiratory Therapy.
- \_\_\_ 8. Completed pre –entrance HESSI exam and **results are attached**. Please read clinical packet for further information. **(Available exam dates are attached)**
- \_\_\_ 7. Submit **\$30.00** to the cashiers office for the application fee and enclose a copy of the receipt.
- \_\_\_ 8. One **self-addressed & stamped** envelope.

After you have done **everything** in the checklist, you will be scheduled for an interview to be held on **May 17, 2018**. You will receive a letter about time and place. You must appear on time for your interview to complete the application process. Sign below to show that you have read and understand these all other directions given in this application packet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TECHNICAL STANDARDS  
For  
RESPIRATORY CARE**

**General Job Description:** Utilize the application of scientific principles for the identification, prevention, remediation, research, and rehabilitation of acute or chronic cardiopulmonary dysfunction, thereby, producing optimum health and function. Reviews existing data, collects additional data, and recommends obtaining data to evaluate the respiratory status of patients, develop the respiratory care plan, and determine the appropriateness of the prescribed therapy. Initiates, conducts, and modified prescribed therapy. Initiates, conducts, and modified prescribed therapeutic and diagnostic procedures such as: administering medical gases, humidification and aerosols, aerosol medications, postural drainage, bronchopulmonary hygiene, cardiopulmonary resuscitation; providing support services to mechanically ventilated patients; maintaining artificial and natural airways; performing pulmonary function testing, hemodynamic monitoring and other physiologic monitoring; collecting specimens of blood and other materials. Documents necessary information in the patient's medical record and on other forms, and communicates that information to members of the health care team. Obtains, assembles, calibrates, and checks necessary equipment. Uses problem solving to identify and correct malfunctions of respiratory care equipment. Demonstrates appropriate interpersonal skills to work productively with patients, families, staff, and co-workers. Accepts directives, maintains confidentiality, does not discriminate and upholds the ethical standards of the profession.

| <b>Physical Standards</b>   | <b>Frequency*</b> |
|---|-------------------|
| Lift: up to 50 pounds to assist moving patients                               | F                 |
| Stoop: to adjunct equipment   | F                 |
| Kneel: to perform CPR   | O                 |
| Crouch: to locate and plug in electrical equipment                            | F                 |
| Reach: 5 ½" above the floor to attach oxygen devices to wall outlet           | C                 |
| Handle: small and large equipment for storing, retrieving, moving             | C                 |
| Grasp: syringes, laryngoscope, endotracheal tubes                             | C                 |
| Stand: for prolonged periods of time (e.g. delivery therapy, check equipment) | C                 |
| Feel: to palpate pulses, arteries for puncture, skin temperature.             | C                 |
| Push/Pull: large, wheeled equipment, e.g. mechanical ventilators              | C                 |
| Walk: for extended periods of time to all areas of a hospital                 | C                 |
| Manipulate: knobs, dials associated with diagnostic/therapeutic devices.      | C                 |
| Hear: verbal directions   | C                 |
| Hear: gas flow through equipment  | C                 |
| Alarms  | C                 |
| Through a stethoscope such as breath or heart sounds                          | C                 |
| See: patient conditions such as skin color, work of breathing                 | C                 |
| Mist flowing through tubing   | F                 |

| <b>Physical Standards</b>  | <b>Frequency*</b> |
|--|-------------------|
| Lift: up to 50 pounds to assist moving patients  | F                 |
| Talk: to communicate in English goals/procedures to patients   | F                 |
| Read: typed, handwritten, computer information in English  | C                 |
| Write: to communicate in English pertinent information (e.g. patient evaluation data, therapy outcomes).   | C                 |
|  |                   |
| <b>Mental/Attitudinal Standards</b>  | <b>Frequency*</b> |
| Functions safely, effectively, and calmly under stressful situations   | F                 |
| Maintain composure while managing multiple tasks simultaneously  | F                 |
| Prioritize multiple tasks.   | C                 |
| Exhibit social skills necessary to interact effectively with patients, families, supervisors, and co-workers of the same or different cultures such as respect, politeness, tact, collaboration, teamwork, discretion. | F                 |
| Maintain personal hygiene consistent with close personal contact associated with patient care  | C                 |
| Display attitudes/actions consistent with the ethical standards of the profession.   | C                 |

\*Frequency Key: O = occasionally 1-33%; F = frequency 34-66% C = constantly 67-100%

- A. The clinical setting is a high-risk area for exposure to patients with communicable diseases, to include exposure to human immunodeficiency virus (HIV) and hepatitis B virus (HBV). Protective procedures are taught and must be followed in the clinical setting.
- B. Respiratory Therapy courses are taken during daytime hours. Due to patient-care schedules, clinical days may be as early as **5:45 a.m.**
- C. A pre-entrance health form will be distributed with acceptance letters. Results of the medical examination must be reported on the designated health form, which is to be **submitted at the pre-clinical orientation prior to the Fall semester**. You may visit a private physician, clinic, health maintenance organization, or medical center for the medical examination.
- D. The pre-entrance medical examination includes a medical history, physical examination and record of current immunizations. Verification of the following immunizations/tests is required of students: tuberculin skin test, varicella vaccination and/or titer, tetanus/diphtheria, measles, mumps, rubella, MMR titer, seasonal flu shot, and hepatitis B vaccination dates and titer if the series has been completed. Completion of this form is mandatory in order to continue on in the clinical phase.
- E. The hepatitis B vaccine is required and involves a series of three (3) injections. Students must have completed the first and second injection of the series prior to entering the hospital for clinical practice. Students must submit documentation following each injection to the Clinical Director. A physician must validate pregnancy or other health situations (i.e., allergies and nursing

mothers), which may prohibit the use of the vaccine, and a waiver signed by the student.

- F. HIV testing is required of all students in the clinical phase of the program. Drug screening will be done randomly; students will incur cost of testing.
- G. Students will be required to take the seasonal flu shot once it becomes available in the fall.
- H. All courses in the Respiratory Therapy Department must be completed in the semester in which it is scheduled. Support courses may be taken prior to or concurrent with required Respiratory Therapy Program curriculum, each course of the program must be passed with a grade of “C” or better in the semester in which it is scheduled.
- I. It is your responsibility to have transportation to the assigned hospitals each semester. Clinical rotations occur in various clinical affiliates as listed below:

Willis-Knighton Medical Center (North)  
Willis-Knighton Medical Center (South)  
Willis-Knighton Medical Center (Bossier)  
Willis-Knighton Medical Center (Pierremont)  
Christus-Schumpert Medical Center (Highland)  
Veterans Administration Medical Center  
Cornerstone Hospital  
Meadowview Hospital (Minden)  
Minden Medical Center  
Lifecare Facilities

- J. All prospective Allied Health clinical students **must** complete a pre-entrance exam. The cost of the exam is \$40.00 and must be paid at the cashier's window prior to arriving for the exam at the MLK Campus Testing Center – Fine Arts Building; Room C-12. The exam is designed to assist students in preparation for entrance into higher education in a variety of health-related professions. The academically oriented subjects consist of: Mathematics, Reading, Vocabulary, Grammar, Biology, Chemistry, Anatomy and Physiology, and Physics. There is a review book that may be purchased for the price of \$34.95 and used as a study guide. The website is [www.elsevierhealth.com](http://www.elsevierhealth.com) and the title is Admission Assessment Exam Review, 2<sup>nd</sup> Edition ISBN: 978-1-4160-5635-5. **The purchase of this text is optional. The available dates for this exam with instructions are attached.**
- K. **This program is currently on probation.**

**METHODS OF LEARNING: Please answer the following questions.**

- A. Are you able to perform the physical and mental/attitudinal standards of this program **with** or **without** reasonable accommodations? If you need accommodations, what kind?
- B. When learning new information or procedures, you retain it better by (you can have more than one answer).
- \_\_\_\_ reading it
  - \_\_\_\_ seeing it
  - \_\_\_\_ listening to someone explain it
  - \_\_\_\_ doing it myself
  - \_\_\_\_ working with a small group to better understand it
  - \_\_\_\_ working alone to better understand it

---

Applicant Signature

---

Date



**RESPIRATORY THERAPY DEPARTMENT  
ACCEPTANCE TALLY SHEET**

---

**A. COLLEGE RECORD (45 points maximum)**

1. College GPA

\_\_\_\_\_ (GPA of 3.8 – 4.0 = 10 points)

\_\_\_\_\_ (GPA of 3.5 – 3.8 = 8 points)

\_\_\_\_\_ (GPA of 3.0 – 3.5 = 6 points)

\_\_\_\_\_ (GPA of 2.5 – 3.0 = 4 points)

*(GPA below 2.5 is NOT eligible for admission to the program)*

2. Courses Taken

Student must have earned at least “B” in order to earn points

\_\_\_\_\_ a. Human Anatomy & Physiology I (5 points)

\_\_\_\_\_ b. Human Anatomy & Physiology II (5 points)

\_\_\_\_\_ c. Freshman English I (5 points)

\_\_\_\_\_ d. Chemistry and Chemistry Lab (5 points)

\_\_\_\_\_ e. College Algebra or higher Mathematics (5 points)

\_\_\_\_\_ f. Physical Science (5 points)

\_\_\_\_\_ g. Microbiology (5 points)

3. Hours taken at Southern University-Shreveport

\_\_\_\_\_ 20 Hours (5 points)

\_\_\_\_\_ 30 Hours (10 points)

**B. Admission Assessment Exam (10 points maximum)**

\_\_\_\_\_ Score of 80 and above (10 points)

\_\_\_\_\_ Score of 70 – 79 (8 points)

\_\_\_\_\_ Score of 60 – 69 (6 points)

\_\_\_\_\_ Score of 50 – 59 (5 points)

**C. NON-ACADEMIC CRITERIA (45 points maximum)**

\_\_\_\_\_ Applicant’s Typed Statement (5 points)

\_\_\_\_\_ Reference Letters (5 points)

\_\_\_\_\_ Pre- Admission Orientation (5 points)

\_\_\_\_\_ Interview (30 points)

TOTAL \_\_\_\_\_



**RESPIRATORY THERAPY DEPARTMENT  
PRE- CLINICAL OREINTATION FORM**

All program applicants **must** attend a program orientation session. These session will only be offered on **May 11, 2018 at 9:00am**. The meeting will be held at the Metro Center in room 422.

This form is to be signed by a clinical instructor and will become a permanent part of your application packet.

I \_\_\_\_\_ attended the pre-clinical orientation  
**PRINTED NAME**

session. I have been provided with a sufficient amount of information of the roles of a respiratory therapy student and a licensed Respiratory Therapists.

**Information Covered:**

**Role of a Respiratory Therapy Student**

**HIPPA**

**Floor Care**

Pediatrics and Adults

**Critical Care**

Neonatal, Pediatrics and Adults

**Long –Term Care**

Neonatal Pediatrics and Adults

**Home Health**

**Specialty Sites**

PFT Hyperbarics Cardiopulmonary Rehabilitation Anesthesia

\_\_\_\_\_  
**Signature of Applicant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Faculty**

\_\_\_\_\_  
**Date**



RESPIRATORY THERAPY DEPARTMENT

# APPLICATION FOR ADMISSION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: \_\_\_\_\_ CITIZENSHIP: \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

STUDEN BANNER ID NUMBER: \_\_\_\_\_

**IN CASE OF EMERGENCY:**

\_\_\_\_\_ (Name of Contact) (Relationship)

\_\_\_\_\_ Street Address City/State/ZIP Code

\_\_\_\_\_ Telephone Cell Phone

**HIGH SCHOOL ATTENDED:**

| Name of School | Dates Attended | Location |
|----------------|----------------|----------|
|                |                |          |
|                |                |          |

**COLLEGE EDUCATION:** List in chronological order all undergraduate colleges attended

| Institution | Location | Dates | Major | Degrees |
|-------------|----------|-------|-------|---------|
|             |          |       |       |         |
|             |          |       |       |         |
|             |          |       |       |         |
|             |          |       |       |         |



## RESPIRATORY THERAPY DEPARTMENT CANDIDATE RECOMMENDATION FORM

**DIRECTIONS:** The purpose of this form is to provide a personal or professional reference for the prospective candidate. Please complete ALL items on the evaluation form and include a brief narrative of your reason(s) for recommending this individual for entrance to the program. Your signature, occupation and the date are necessary for completion of this document. Your address and telephone number are optional, but helpful for future reference if needed. All information you provide is protected by the Family Education Rights & Privacy Act of 1974 and is held in strict confidence. If you have any questions, please contact Mrs. Katrina Harris, Director of Clinical Education/Admissions Chairperson at 318.670.9624 for information.

**Candidate's Name:** \_\_\_\_\_

**Length of time you have known Candidate:** \_\_\_\_\_ [ ]Months [ ]Years

**Professional/Personal Relationship:** \_\_\_\_\_  
*(Employer/Supervisor, Instructor/Pastor, Personal Friend, etc. If you are a relative, please help the candidate select another person to complete a recommendation form).*

**Please rate the Candidate's abilities and attributes according to the following scale:**

**4 = Excellent      3 = Good      2 = Average      1 = Fair      0 = Poor**  
 Use "N" for Non-applicable or No-opinion judgments

| ABILITIES AND ATTRIBUTES                                      | SCORE |
|---|-------|
| Judgment, decisiveness, considers alternatives                |       |
| Assertiveness, Firmness in stating position                   |       |
| Professional commitment, knowledge                            |       |
| Oral expression, clarity and articulation                     |       |
| Independence, initiative, minimal need for supervision        |       |
| Mood stability, performs well under pressure, level-headed    |       |
| Demeanor, responsiveness to needs/moods of others             |       |
| Industriousness, perseverance, and endurance                  |       |
| Dependability and follow-through                              |       |
| Leadership, ability to give direction and organize duties     |       |
| Integrity, ability to maintain privacy and avoid gossip       |       |
| Self-understanding, awareness of own strengths/weakness       |       |
| Inquisitiveness: Eagerness to learn                           |       |
| Cooperation: Willingness and ability to work with others      |       |
| Written Communication: Clear, grammatically correct writing   |       |
| Personal Appearance: Well-groomed, occasion appropriate dress |       |

*(Please continue on the next page)*

Please use the space below to explain any of the scores in the previous rating table with further comments. (Include additional pages if needed).

---

---

---

---

Please use the space below to describe your knowledge of the candidate's strengths of weaknesses as they pertain to his/her suitability for program admission. (Include additional pages if needed).

---

---

---

---

---

---

---

---

**EVALUATOR INFORMATION:** Provide your **SIGNATURE, PRINTED NAME, DATE** and **TITLE/OCCUPATION** SO THAT WE CAN VERIFY TO THE CANDIDATE THAT YOUR RECOMMENDATION IS ON FILE. **ADDRESS AND TELEPHONE NUMBER ARE OPTIONAL.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME \_\_\_\_\_  
(Please Print)

TITLE/OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

**PLEASE RETURN TO:** Southern University at Shreveport, LA  
Respiratory Therapy Technology Program  
610 Texas Street/Suite 211  
Shreveport, LA 71101  
ATTENTION: Katrina Harris

\*\*\*\*(You may return this to the candidate to deliver personally)



## RESPIRATORY THERAPY DEPARTMENT CANDIDATE RECOMMENDATION FORM

**DIRECTIONS:** The purpose of this form is to provide a personal or professional reference for the prospective candidate. Please complete ALL items on the evaluation form and include a brief narrative of your reason(s) for recommending this individual for entrance to the program. Your signature, occupation and the date are necessary for completion of this document. Your address and telephone number are optional, but helpful for future reference if needed. All information you provide is protected by the Family Education Rights & Privacy Act of 1974 and is held in strict confidence. If you have any questions, please contact Mrs. Katrina Harris, Director of Clinical Education/Admissions Chairperson at 318.670.9624 for information.

**Candidate's Name:** \_\_\_\_\_

**Length of time you have known Candidate:** \_\_\_\_\_ [ ]Months [ ]Years

**Professional/Personal Relationship:** \_\_\_\_\_  
*(Employer/Supervisor, Instructor/Pastor, Personal Friend, etc. If you are a relative, please help the candidate select another person to complete a recommendation form).*

**Please rate the Candidate's abilities and attributes according to the following scale:**

**4 = Excellent      3 = Good      2 = Average      1 = Fair      0 = Poor**

Use "N" for Non-applicable or No-opinion judgments

| ABILITIES AND ATTRIBUTES                                      | SCORE |
|---|-------|
| Judgment, decisiveness, considers alternatives                |       |
| Assertiveness, Firmness in stating position                   |       |
| Professional commitment, knowledge                            |       |
| Oral expression, clarity and articulation                     |       |
| Independence, initiative, minimal need for supervision        |       |
| Mood stability, performs well under pressure, level-headed    |       |
| Demeanor, responsiveness to needs/moods of others             |       |
| Industriousness, perseverance, and endurance                  |       |
| Dependability and follow-through                              |       |
| Leadership, ability to give direction and organize duties     |       |
| Integrity, ability to maintain privacy and avoid gossip       |       |
| Self-understanding, awareness of own strengths/weakness       |       |
| Inquisitiveness: Eagerness to learn                           |       |
| Cooperation: Willingness and ability to work with others      |       |
| Written Communication: Clear, grammatically correct writing   |       |
| Personal Appearance: Well-groomed, occasion appropriate dress |       |

*(Please continue on the next page)*

Please use the space below to explain any of the scores in the previous rating table with further comments. (Include additional pages if needed).

---

---

---

---

Please use the space below to describe your knowledge of the candidate's strengths of weaknesses as they pertain to his/her suitability for program admission. (Include additional pages if needed).

---

---

---

---

---

---

---

---

**EVALUATOR INFORMATION:** Provide your **SIGNATURE, PRINTED NAME, DATE** and **TITLE/OCCUPATION** SO THAT WE CAN VERIFY TO THE CANDIDATE THAT YOUR RECOMMENDATION IS ON FILE. **ADDRESS AND TELEPHONE NUMBER ARE OPTIONAL.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME \_\_\_\_\_  
(Please Print)

TITLE/OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

**PLEASE RETURN TO:** Southern University at Shreveport, LA  
Respiratory Therapy Technology Program  
610 Texas Street/Suite 211  
Shreveport, LA 71101  
ATTENTION: Katrina Harris

\*\*\*\*(You may return this to the candidate to deliver personally)



## RESPIRATORY THERAPY DEPARTMENT CANDIDATE RECOMMENDATION FORM

**DIRECTIONS:** The purpose of this form is to provide a personal or professional reference for the prospective candidate. Please complete ALL items on the evaluation form and include a brief narrative of your reason(s) for recommending this individual for entrance to the program. Your signature, occupation and the date are necessary for completion of this document. Your address and telephone number are optional, but helpful for future reference if needed. All information you provide is protected by the Family Education Rights & Privacy Act of 1974 and is held in strict confidence. If you have any questions, please contact Mrs. Katrina Harris, Director of Clinical Education/Admissions Chairperson at 670-9624 for information.

**Candidate's Name:** \_\_\_\_\_

**Length of time you have known Candidate:** \_\_\_\_\_ [ ]Months [ ]Years

**Professional/Personal Relationship:** \_\_\_\_\_  
*(Employer/Supervisor, Instructor/Pastor, Personal Friend, etc. If you are a relative, please help the candidate select another person to complete a recommendation form).*

**Please rate the Candidate's abilities and attributes according to the following scale:**

**4 = Excellent      3 = Good      2 = Average      1 = Fair      0 = Poor**

Use "N" for Non-applicable or No-opinion judgments

| ABILITIES AND ATTRIBUTES                                      | SCORE |
|---|-------|
| Judgment, decisiveness, considers alternatives                |       |
| Assertiveness, Firmness in stating position                   |       |
| Professional commitment, knowledge                            |       |
| Oral expression, clarity and articulation                     |       |
| Independence, initiative, minimal need for supervision        |       |
| Mood stability, performs well under pressure, level-headed    |       |
| Demeanor, responsiveness to needs/moods of others             |       |
| Industriousness, perseverance, and endurance                  |       |
| Dependability and follow-through                              |       |
| Leadership, ability to give direction and organize duties     |       |
| Integrity, ability to maintain privacy and avoid gossip       |       |
| Self-understanding, awareness of own strengths/weakness       |       |
| Inquisitiveness: Eagerness to learn                           |       |
| Cooperation: Willingness and ability to work with others      |       |
| Written Communication: Clear, grammatically correct writing   |       |
| Personal Appearance: Well-groomed, occasion appropriate dress |       |

*(Please continue on the next page)*

Please use the space below to explain any of the scores in the previous rating table with further comments. (Include additional pages if needed).

---

---

---

---

Please use the space below to describe your knowledge of the candidate's strengths of weaknesses as they pertain to his/her suitability for program admission. (Include additional pages if needed).

---

---

---

---

---

---

---

---

**EVALUATOR INFORMATION:** Provide your **SIGNATURE, PRINTED NAME, DATE** and **TITLE/OCCUPATION** SO THAT WE CAN VERIFY TO THE CANDIDATE THAT YOUR RECOMMENDATION IS ON FILE. **ADDRESS AND TELEPHONE NUMBER ARE OPTIONAL.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME \_\_\_\_\_  
(Please Print)

TITLE/OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

**PLEASE RETURN TO:** Southern University at Shreveport, LA  
Respiratory Therapy Technology Program  
610 Texas Street/Suite 211  
Shreveport, LA 71101  
ATTENTION: Katrina Harris

\*\*\*\*(You may return this to the candidate to deliver personally)



**RESPIRATORY THERAPY DEPARTMENT  
CANDIDATE RECOMMENDATION FORM**

**DIRECTIONS:** The purpose of this form is to provide a personal or professional reference for the prospective candidate. Please complete ALL items on the evaluation form and include a brief narrative of your reason(s) for recommending this individual for entrance to the program. Your signature, occupation and the date are necessary for completion of this document. Your address and telephone number are optional, but helpful for future reference if needed. All information you provide is protected by the Family Education Rights & Privacy Act of 1974 and is held in strict confidence. If you have any questions, please contact Mrs. Katrina Harris, Director of Clinical Education/Admissions Chairperson at 318.670.9624 for information.

**Candidate's Name:** \_\_\_\_\_

**Length of time you have known Candidate:** \_\_\_\_\_ [ ]Months [ ]Years

**Professional/Personal Relationship:** \_\_\_\_\_  
*(Employer/Supervisor, Instructor/Pastor, Personal Friend, etc. If you are a relative, please help the candidate select another person to complete a recommendation form).*

**Please rate the Candidate's abilities and attributes according to the following scale:**

**4 = Excellent      3 = Good      2 = Average      1 = Fair      0 = Poor**

Use "N" for Non-applicable or No-opinion judgments

| ABILITIES AND ATTRIBUTES                                      | SCORE |
|---|-------|
| Judgment, decisiveness, considers alternatives                |       |
| Assertiveness, Firmness in stating position                   |       |
| Professional commitment, knowledge                            |       |
| Oral expression, clarity and articulation                     |       |
| Independence, initiative, minimal need for supervision        |       |
| Mood stability, performs well under pressure, level-headed    |       |
| Demeanor, responsiveness to needs/moods of others             |       |
| Industriousness, perseverance, and endurance                  |       |
| Dependability and follow-through                              |       |
| Leadership, ability to give direction and organize duties     |       |
| Integrity, ability to maintain privacy and avoid gossip       |       |
| Self-understanding, awareness of own strengths/weakness       |       |
| Inquisitiveness: Eagerness to learn                           |       |
| Cooperation: Willingness and ability to work with others      |       |
| Written Communication: Clear, grammatically correct writing   |       |
| Personal Appearance: Well-groomed, occasion appropriate dress |       |

*(Please continue on the next page)*



Please use the space below to explain any of the scores in the previous rating table with further comments. (Include additional pages if needed).

---

---

---

---

Please use the space below to describe your knowledge of the candidate's strengths of weaknesses as they pertain to his/her suitability for program admission. (Include additional pages if needed).

---

---

---

---

---

---

---

---

**EVALUATOR INFORMATION:** Provide your **SIGNATURE, PRINTED NAME, DATE** and **TITLE/OCCUPATION** SO THAT WE CAN VERIFY TO THE CANDIDATE THAT YOUR RECOMMENDATION IS ON FILE. **ADDRESS AND TELEPHONE NUMBER ARE OPTIONAL.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME \_\_\_\_\_  
(Please Print)

TITLE/OCCUPATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_

**PLEASE RETURN TO:** Southern University at Shreveport, LA  
Respiratory Therapy Technology Program  
610 Texas Street/Suite 211  
Shreveport, LA 71101  
ATTENTION: Katrina Harris

\*\*\*\*(You may return this to the candidate to deliver personally)



**Students who are planning to apply to either of the programs listed below:**

**Medical Coding  
Health Information Technology  
Medical Lab Technology  
Radiologic Technology  
Respiratory Therapy  
Surgical Technology**

**Are now required to take a pre-admission exam!!!!**

**Place: Metro Center 610 Texas Suite 105**

**Contact: Mrs. Whitaker @ 670-9627 to schedule your exam.**

**Cost of exam: \$40.00**

**Students MUST go to Cashier's Window (MLK campus) to make payment and present paid receipt before taking the exam. Otherwise, there will be no admittance into the test center.**

**Dates & Times: March 2017 (4 hours allotted)**

March 28 (8:15 AM), 29 (12:45 PM)  
31 (8:15 AM)

**Dates & Times: April 2017 (4 hours allotted)**

April: 11, 12, 18, 20, 21, 25: (08:15)  
10, 13, 17, 19 (12:45)

**Dates & Times: May 2017 (4 hours allotted)**

May 2, 4, 11, 16, 23, 25, 30 (8:15 AM)

9, 17, 18, 22, 29, (12:45 PM)

19, 26 (0800 AM)

**Limited seating available**

Revised January 10, 2018

## **RESPIRATORY THERAPY CLINICAL FEES**

### **Pre- Clinical Fees:**

#### **Application Fee**

**25.00**

#### **Non- Refundable**

**Vendor: Southern University Respiratory Therapy Program**

**Explanation: This fee is used to defray the costs associated with the student applicant interview process.**

#### **HESSI Exam**

**40.00**

**Non- Refundable Vendor: Elsevier/Evolve**

**Paid to the University cashier**

**Explanation: This is the entrance exam used for students entering in the program. The score from this test is one of the criteria used to admit students into the respiratory program. The fee is assessed by the vendor.**

### **Freshman Fees:**

#### **BLS Fee**

**55.00**

**Non-Refundable Vendor: Claudine Matthews**

**610 Texas St.**

**Shreveport, LA 71112**

**Explanation: Students are required by the Commission on Accreditation for Respiratory Care to obtain certification in CPR in order to treat patients in the clinical settings RESP109**

**Physical Exam, Lab results, Immunizations, TB Skin test, flu shot, drug screen**

**COST VARIES by physician Vendor: Physician**

**Explanation: ONLY STUDENTS SELECTED TO ENTER THE CLINICAL PHASE OF THE PROGRAM ARE REQUIRED TO COMPLETE THESE TEST IN ORDER TO ENTER THE CLINICAL SETTINGS. RESP109**

**Entrance Fee**

**55.00**

**Non- Refundable Vendor: Southern University Respiratory Therapy Program**

**Explanation: This fee is charged to students for classroom items such as: printer ink, calculators, pencils, scantrons, etc. RESP109**

**Background Check**

**\$ 65.00**

**Non-Refundable Vendor: Southern Research Company Inc.**

**2850 Centenary Blvd, Shreveport, LA 71104**

**Explanation: Students are required to pass a criminal background check per clinical site request. RESP 109**

**Mid Mastery Exit Exam (secured)**

**\$ 45.00**

**Non-Refundable Vendor: AMP**

**<http://www.goamp.com/>**

**Explanation: Students are required to purchase complete a mid-mastery exam at entry level in order to progress to the 2nd level. RESP 130**

**AARC Membership Fee \$50.00**

**Non - Refundable Vender: American Association of Respiratory Care**

**9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706**

**Explanation: Students are required to join the Respiratory Therapy professional association in efforts to stay current with conferences and receive discounts on test and events. RESP 109**

**Uniform Expense VARIES +\$5 for uniform patch Vendor: Student preference**

**Explanation: Students will need to purchase a specific color uniform to ensure uniformity in the hospital site. RESP 109**

**Senior Fees:**

**ACLS Fee 70.00**

**Non-Refundable Vendor: Cheryl Blackshire**

**610 Texas St.**

**Shreveport, LA 71112**

**Explanation: Students are required by the Commission on Accreditation for Respiratory Care to obtain certification in CPR in order to treat patients in the clinical settings RESP 261**

**Kettering Review Seminar 425.00 Non- Refundable**

**Vendor: KETTERING NATIONAL SEMINARS**

**590 Congress Park Dr, Dayton, OH 45459**

**Explanation: This is the cost for the review seminar which will prepare for their national exam. RESP 261**

**National Exit Exam (secured) \$136.00**

**Non- Refundable Vendor: AMP**

**<http://www.goamp.com/>**

**Explanation: Students are required to purchase complete an exit exam at registry level in order to progress to graduate. RESP 261**

**Background Check by State \$ 65.00**

**Non-Refundable Vendor: LSBME**

**Explanation: Students are required to pass a criminal background check performed by the state licensing board in order to receive credentials. This fee is paid directly to the LSBME by the student. RESP 261**

**National Exam Fee \$190**

**Non-Refundable Vendor: NBRC**

**Explanation: Students are required to take a national board exam in order to receive credentials. This fee is paid directly to the NBRC by the student. RESP 261**

**License Fee \$167.00**

**Non-Refundable Vendor: State Licensing Board**

**Explanation: Students are required to pay for licensing in any state they intend to work. This fee is paid directly to the states listening board by the student. RESP 261**