MEDICINE HAT COLLEGE

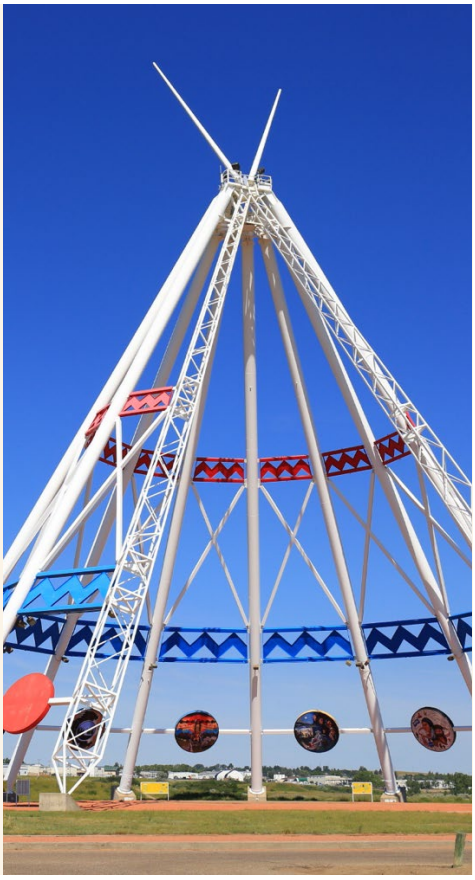
Health Care Aide
Yuill School of Health and Community Services

Orientation Package

FALL 2025

Territorial Acknowledgement

Medicine Hat College honours and acknowledges the traditional territories of the First Nation People of the Treaty 7, Treaty 4, and Métis people who share a deep history with this land. We recognize and honour the land, history, ways of being, and our relationship with First Nation, Métis, and Inuit people as we forge together toward a relationship of reconciliation, respect, understanding, and healing.



HEALTH CARE AIDE

Yuill School of Health & Community Services
Medicine Hat College
299 College Drive SE
Medicine Hat, AB, Canada
T1A 3Y6
(403) 504-3626 or 1-866-282-8394
www.mhc.ab.ca

Table of Contents

Welcome to the Program

We are pleased to welcome you into the Health Care Aide program at Medicine Hat College. This package is a follow up to your acceptance letter from Admissions.

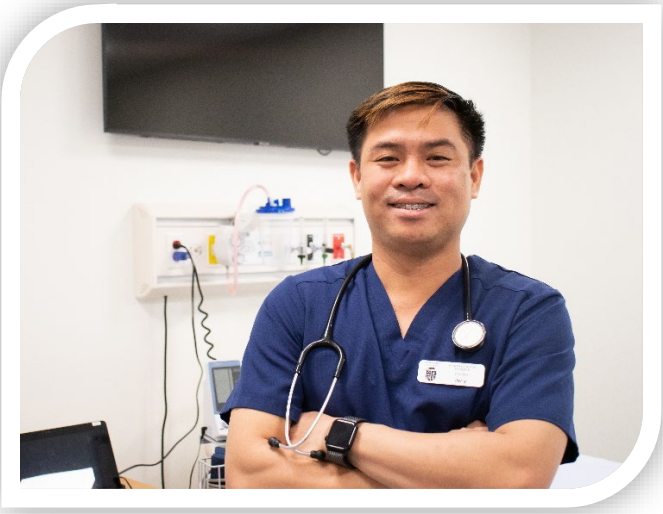
The Government of Alberta HCA Curriculum (2019) is offered through Medicine Hat College at both the Medicine Hat and Brooks campuses. Individuals with related work experience as a Health Care Aide may be evaluated through Prior Learning Assessment. With flexible delivery options and strong employment opportunities, get ready to launch a rewarding career in health care.

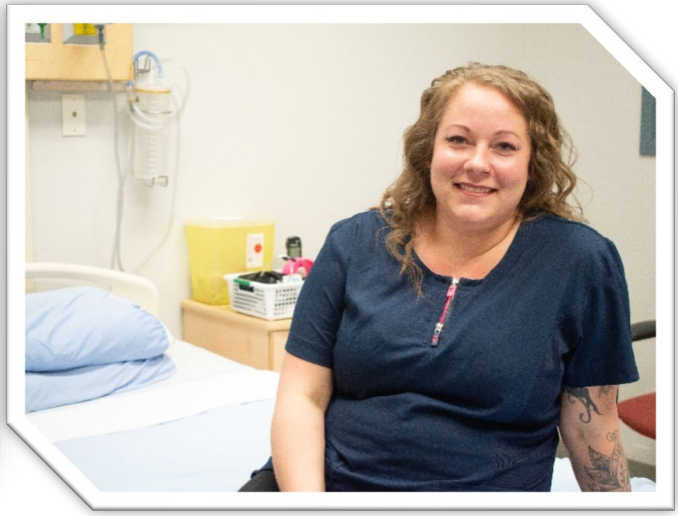
There are several forms that you are required to complete and submit as soon as possible. Please find further information about the forms in this package. Please watch your MHC email for information on registration and New Student Orientation.

For further information about Medicine Hat College itself, please refer to the College website www.mhc.ab.ca**.** If you have any questions or concerns about our program or information in this package, please do not hesitate to contact our Administrative Assistant at HStudiesInquiries@mhc.ab.ca

Sincerely,

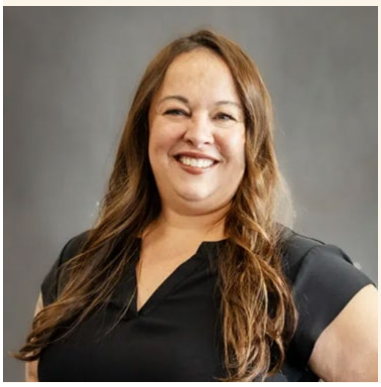
The Health Care Aide Team





Meet the Team

Here are some key members of our team that may be a part of your college journey. Please note that specific names of employees in these positions may change over time. If the person listed below is not available, you may call our toll-free number (accessible throughout North America) at 1-866-282-8394 and ask for the staff member who is now in that role.

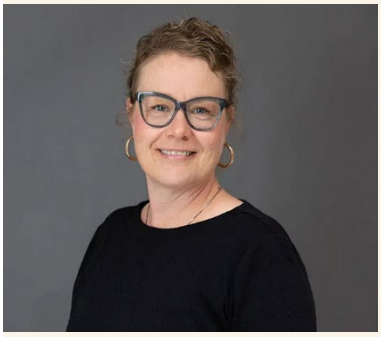


Kerry Douville

Health Care Aide Program Coordinator

Instructor at Brooks College Campus

Phone: 403-362-1473
Email: KDouville@mhc.ab.ca



Anne Obermeyer

Health Care Aide Program Instructor at Medicine Hat College Campus

Phone: 403-529-3811
Email: AObermeyer@mhc.ab.ca

Kaytlynn Neil

Health Care Aide Program Instructor at Medicine Hat College Campus

Phone: 403-548-5132
Email: Kneil@mhc.ab.ca

ROLE	HOW THEY CAN HELP YOU
Program Administrative Assistant Phone: 403-504-3626 Email: Hstudiesinquiries@mhc.ab.ca	• Being your initial program contact once you have been admitted to the program. • Collecting and confirming that your forms have been received, recorded and are kept current. • Being your “go-to” for any program-related questions.
Academic Advisor **Kamal Sagoo** Phone: 403-362-1682 Email: ksagoo@mhc.ab.ca	• Creating your plan of study. • Registering for a course offered by Medicine Hat College. • Modifying and updating your program plan of study with you. • General information about the programs. • Withdrawing from a course if necessary.
Prior Learning Assessment and Recognition (PLAR) Advisor Email: transfer@mhc.ab.ca	• Understanding the PLAR process. • Helping you to determine if you should pursue PLAR. • Gathering and evaluating documents for PLAR.
Accessibility Services **Tara Watkins** Phone: 403-529-3824 Email: twatkins@mhc.ab.ca	• Assist you with planning for reasonable accommodations. • Act as the primary contact for students with disabilities. • Coordinate all policy-related and procedural issues. • Advise you regarding disability-related academic matters, if required.
Student Placement Officer **Michelle Robinson** Phone: 403-529-3914 Email: mrobinson@mhc.ab.ca	• Organizing clinical placements required for the program. • Contacting clinical sites on behalf of the student and MHC.

Important Dates

REQUIRED DOCUMENT SUBMISSION DEADLINE

June 30, 2025

There are important documents/forms you will need to complete and submit prior to your entry into the program. Refer to the Required Documentation section for a list of these documents and be sure to submit them before the deadline based on your start date for entry into the program.

NEW STUDENT ORIENTATION

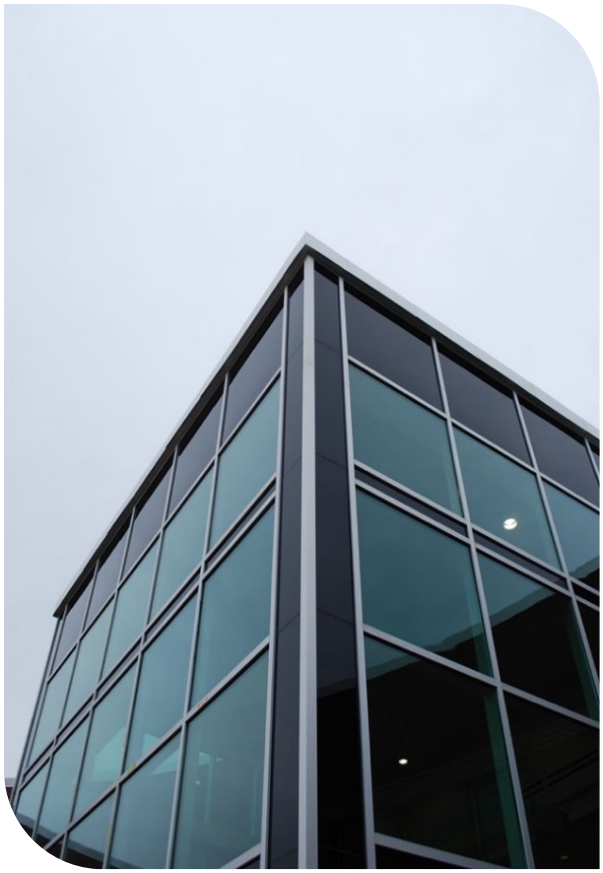
Wednesday, September 2, 2025

New Student Orientation is the best way to dive into your college experience! This event at the beginning of the semester will give you information about what to expect during your time at MHC, so it is strongly encouraged that you participate. It's also a great opportunity to familiarize yourself with your program and meet your new classmates!

FIRST DAY OF CLASSES

Thursday, September 3, 2025

On the first day of class, your instructor may review the course outline, as well as expectations and responsibilities. You should come to class prepared to learn!



FOR MORE INFORMATION

Please visit the MHC website to learn more: www.mhc.ab.ca

You should familiarize yourself with the Academic Calendar to see other important dates and college policies.

Here you can also find Course outlines and Library Services

For technology support, please contact IT services at: callcentre@mhc.ab.ca

For laptop rentals please contact Registration at registration@mhc.ab.ca

If you have any additional questions or concerns about the program or information in this letter, please do not hesitate to contact us: HStudiesInquiries@mhc.ab.ca

Required Learning Resources

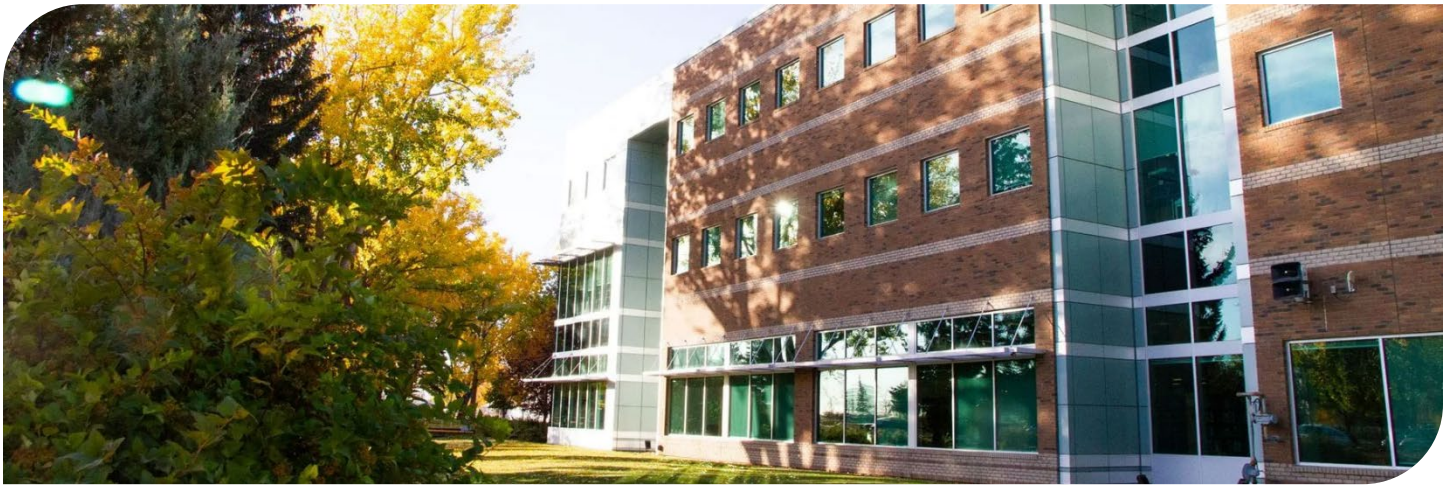
REQUIRED TEXTBOOKS AND LEARNING RESOURCES

Required learning resources to be purchased **before the first day of classes**:

- Sorrentino's Canadian Textbook for the Support Worker, Elsevier, 5th Ed.
- Clinical Skills: Skills for Nurse Assisting, 1st Edition
- HCAP Pkg Term 1: 140-144

These can be purchased online here. Alternatively, you can purchase these items directly at the Medicine Hat College Bookstore during operating hours.

Brooks students: Please purchase online and select delivery to the Brooks campus. Deliveries occur on Mondays and Thursdays.



Required Documentation

Prior to entry in the program, the following documentation/forms MUST be completed and submitted on or before the deadline(s). These requirements are set out in the Medicine Hat College Academic Calendar and are pre-program requirements. All costs associated with these requirements are the responsibility of the student. Email your completed documents to the Program Administrative Assistant:

HStudiesInquiries@mhc.ab.ca

Email Details

Be sure to include the following in your email:

- Your full name
- Program of study
- Year that you enrolled in

Submission Deadline

Documents due no later than June 30th

☐ **Emergency Contact Form and Health Form:**

By completing this form, you confirm that you are both physically and mentally fit to practice as a health care student. Additionally, please provide us with an emergency contact who can be reached in case of an emergency.

☐ **General Release of Personal Data**

The purpose of this form is to obtain your permission for the disclosure of information gathered during your studies at Medicine Hat College.

☐ **Oath of Confidentiality Form**

This form will outline the student's responsibility for handling personal information that they may acquire as a student in the program at Medicine Hat College, while on clinical assignments.

☐ **Immunizations:**

Please submit your Immunization Record to immunizations@mhc.ab.ca Refer to Directions for Completing the Immunization Requirements on how to obtain this information. If f your immunizations are not yet complete, email any relevant documentation and keep us updated. Visit our website for information on required and recommended immunizations.

N95 Mask Fit:

You are required to obtain and maintain a current N95 Mask Fit to enter facilities for labs or clinical placements. The costs of the assessment will be the responsibility of the student. Fit testing will be completed on campus. You can purchase your fit test from the Bookstore. Please retain a copy of your receipt to present to your fit tester as proof of purchase.

CPR Certificate

You are required to obtain and maintain current CPR (Health Provider Level) Certification in order to enter the facilities for labs or clinical placements. The costs of such certifications will be the responsibility of the student.
You must provide a current, valid copy of your CPR certificate through one of the following **Canadian training institutions**:

- Heart & Stroke Foundation of Canada
- Canadian Red Cross
- St. John's Ambulance

Please note:

- Any level from a Canadian training institution is acceptable.
- First Aid is not required.
- Online only training will not be accepted.
- CPR training must have a hands-on component.

Police Information Check (PIC) with Vulnerable Sector Check (VSC)

Please submit a copy of your current PIC dated within 3 months of starting the program. This is obtained from your local RCMP or Police Service. Indicate on your application that this is for a practicum experience.

Please note that students reaching age 18 before November 15, should provide a PIC and VSC prior commencement of the first clinical course in November. Students reaching age 18 on or after November 15, must first provide a PIC. Subsequently, upon reaching the age of 18, they are required to submit a VSC.

A non-clear PIC does not necessarily mean that you will forfeit your seat in the program. However, while in school, a criminal conviction may impact or determine whether you can enter particular clinical placements. ****Any changes to Police Information Check status during the Program, must be communicated to the Program Coordinator.****

You must keep your original as you may be required to produce it at clinical sites. A PIC may be requested throughout the program as per program and/or agency policy. Costs for this will be the responsibility of the student. If you have any concerns regarding this, please contact the Program Coordinator.

☐ **HSPnet Form**

The Health Sciences Placement Network, or HSPnet, provides a secure online system for managing practice education in the health sciences across Canada. This is a required consent form that allows MHC to share your information with HSPnet in order to coordinate placement experiences.

☐ **AHS Confidentiality & User Agreement Form**

This is an agreement between you and Alberta Health Services that states your responsibility for handling personal information that you may acquire as a student while on clinical assignments.

Email documents to HStudiesInquiries@mhc.ab.ca

MEDICINE HAT COLLEGE

EMERGENCY CONTACT & HEALTH FORM

In the event of an emergency, we request that you provide us with an emergency contact.

IN CASE OF EMERGENCY PLEASE PROVIDE THE FOLLOWING INFORMATION

_____ _____

Name of Person to Contact in Case of Emergency Relationship

_____

Telephone Number

As per Alberta Health, Health Workforce Planning and Accountability Health Care Aide Competency Profile, 2018, **"I am at a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity."**

In addition, I consider myself able to meet the academic demands of the Health Care Aide Program.

_____

Student's Name

_____

Student's Signature

_____

Date

Protection of Privacy *– The personal information requested on this form is collected under the authority of the Post-secondary Learning Act and Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. The information will be used for the purposes of the delivery and administration of educational training or services. Questions concerning the collection, use, or disposal of this information should be directed to* ***your department Chair or the FOIP Coordinator at foip@mhc.ab.ca.***

GENERAL RELEASE OF PERSONAL DATA

Medicine Hat College Operates within Alberta's Freedom of Information and Protection of Privacy Act (FOIP). This act, which applies to all Alberta post-secondary institutions, states that personal information may only be collected and disclosed for purposes consistent with those of the organization, and that individuals be aware of what information is being collected and how the information will be used and disclosed.

The purpose of this form is to gather your permission for the disclosure of information gathered during your studies at Medicine Hat College.

Police Information Record Check, Immunization Patient Records, and status.

Purpose of Disclosure

To Facilitate clinical placement.

☐ I hereby provide permission to disclose the information noted above for the stated purpose.

Student Name: _____

Signature: _____

Date: _____

Program: _____

MEDICINE HAT COLLEGE

HEALTH CARE AIDE PROGRAM

OATH OF CONFIDENTIALITY

I, _____, agree that I shall not disclose to anyone or use at any time either during and/or after completion of the **Medicine Hat College Health Care Aide Program**, any confidential information of the services or any persons that I have observed or with whom I have had interaction..

All information which comes to me from personal files or during any of the activities connected with me as a student in the **Medicine Hat College Health Care Aide Program**, shall be kept confidential at all times and not disclosed, by me, to any person(s) for any reasons whatsoever. Assignments will be presented to instructors without the client's name or any other identifying features, i.e., address, social insurance numbers, etc.

I understand that failure to adhere to the above could result in my dismissal from the **Medicine Hat College Health Care Aide Program** and leave me subject to legal procedures.

Signed and witnessed this _____ day of _____, 20 ___.

_____ (witness)

_____ (student)

Protection of Privacy *– The personal information requested on this form is collected under the authority of the Post-secondary Learning Act and Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. The information will be used for the purposes of the delivery and administration of educational training or services. Questions concerning the collection, use, or disposal of this information should be directed to* ***your department Chair or the FOIP Coordinator at foip@mhc.ab.ca.***

DIRECTIONS FOR COMPLETING IMMUNIZATIONS

All health care students must be immunized according to AHS Standards as pre-program requirements. Please note that clinical placements may be refused to students who are not compliant with this standard. Be aware that immunization completion takes time in some cases.

The following documents are required by our Immunization Officer to complete your immunization review. Email these documents to immunizations@mhc.ab.ca as soon as completed. If immunizations are incomplete, you need to submit a confirmation date for completion of any outstanding vaccinations/tests.

If you have any questions about this process, please please visit our website for more information email those questions to Immunizations@mhc.ab.ca.

☐ Alberta Health Services Client Immunization Record:

1. Please request your immunization history from your provincial public health agency or from your country of origin.
2. Book an appointment with Medicine Hat Community Health Services or Brooks Health Centre to present your immunization records for review and verification.
3. After your appointment with public health, please request your official AHS Client Immunization Record. Email to Immunizations@mhc.ab.ca

Medicine Hat Community Health Services
2948 Dunmore Road SE
Medicine Hat, Alberta
T1A 8E3
Phone: 403-502-8200

Brooks Health Centre
440 3rd Street E
Brooks, Alberta
T1R -X8
Phone: 403-501-3232

☐ Hepatitis B Immunity Documentation

If applicable, this can be a letter from public health stating you have immunity (protection) against Hep B or your Hep B lab result.

☐ Varicella Immunity Documentation

If applicable, this can be a letter from public health stating you have immunity (protection) against Varicella or your varicella lab result.

☐ Tuberculosis Documentation

If applicable, written confirmation from Public Health Nurse/physician that proper Tuberculosis follow up has been completed after a positive/significant Tuberculosis Skin Test result (TST reading of >10 mm).

HSPNET CONSENT FORM FOR USE AND DISCLOSURE OF STUDENT INFORMATION

Student Number:_____ Educational Program:_____

First Name: _____ Middle Initial: _____ Last Name: _____

1. Permission to Use and Disclose Your Student Related Personal Information and Personal Health Information

By signing this consent, you authorize your educational Program_____to:

- Collect, use and/or disclose your personal information (name and student profile information that is under the custody and control of your Program) to authorized staff of Receiving Agencies for the purpose of locating and coordinating an appropriate placement experience (e.g. clinical practica, fieldwork, or preceptorship) as required by your educational program;
- Use your student related personal information and personal health information relating to placement prerequisites, for the purpose of tracking your compliance against Receiving Agency safety and infection control prerequisites for accepting students. Placement prerequisites that may be tracked include personal information such as CPR certification or criminal records check status, and personal health information such as immunity/immunization status of vaccine-preventable diseases. Placement prerequisite information is used only by staff involved with your educational program, and is never disclosed to users external to your educational program.
- Disclose your personal information to the owner and administrator of the HSPnet system, namely Provincial Health Services Authority British Columbia (PHSA), to allow PHSA to indirectly collect your personal information to provide HSPnet student placement services.

2. Consent Period

This consent is effective immediately and shall remain valid for up to six years, or shall be voided upon your completion of the Program, your formal withdrawal from the Program, or upon written request as described below .

3. Your Rights with respect to this consent

3.1 Right to Refuse Consent - You have the right to refuse to sign this consent, and if you refuse your placement will be processed manually at the earliest convenience of the Program and Receiving Agency.

3.2 Right to Review Privacy & Security Policies - A copy of the document entitled *Identified Purposes and Handling of Personal Information in HSPnet*, which summarizes Privacy and Security policies relating to how we may use and disclose your personal information via HSPnet, is distributed with this Consent Form. You may wish to review the complete Privacy and Security Policies for HSPnet before signing this consent. The Privacy and Security Policies may be amended from time to time, and you may obtain an updated copy by contacting privacy@hspcanada.net.

3.3 Right to Request Restrictions on Use/Disclosure – You have the right to request that we restrict how we use and/or disclose your personal information or personal health information via HSPnet for the purpose of locating and coordinating a suitable placement experience. Such requests must be made in writing to the placement coordinator for your Program. If we agree to a restriction you have requested, we must restrict our use and/or disclosure of your personal information in the manner described in your request. If this restriction precludes our ability to coordinate your placement via HSPnet, then your placement will be processed manually at the earliest convenience of the placement coordinator and receiving agency.

3.4 Right to Revoke Consent - You have the right to revoke this consent at any time. Your revocation of this consent must be in writing to the placement coordinator for your Program. Note that your revocation of this consent, or the voiding of this consent upon your completion or withdrawal from the Program, would not be retroactive and would not affect uses or disclosures we have already made according to your prior consent.

3.5 Right to Receive a Copy of This Consent Form - You may request a copy of your signed consent form.

Collection of your personal information is done under the authority of the privacy legislation that applies to educational institutions in your province. For more information visit https://hspcanada.net/privacy-and-security/

I hereby authorize my educational Program to use and/or disclose my personal information via HSPnet for the purpose of locating and coordinating appropriate student placement(s) as required by the curriculum.

_____ _____

Signature of Student Date (MMM/DD/YYYY)

Student Consent Basic - Form A - NO TRANSFER – June 9, 2020

Alberta Health Services

CONFIDENTIALITY & USER AGREEMENT

Alberta Health Services (AHS) is responsible for protecting the confidentiality of information that it collects, uses, stores and discloses over the course of its operations. You will have access to AHS information as part of your duties and responsibilities related to your role at AHS. This document describes how you, when acting as an AHS Affiliate (defined under the Health Information Act), must handle AHS information, including AHS information systems, and will help you comply with relevant AHS policies. (Refer to Information and Technology Management policies on *www.albertahealthservices.ca/210.asp*.)

This form is to be completed by all employees, Medical Staff, residents/trainees, volunteers, researchers, students, educators, Board Members and midwives. Completion by all members of the Medical Staff is a prerequisite for medical staff appointment.

Completed forms will be retained in the appropriate corresponding program files. Managers/Supervisors are to send forms for AHS employees to Human Resources by fax to 1-888-908-4408 or email at *hrdataadmin.ahs@albertahealthservices.ca*.

For members of the AHS Medical Staff, please forward this signed form to their primary zone's Medical Affairs Office after completing the required AHS Privacy and Security Training. It will be retained on file in compliance with Medical Staff Bylaws.

Completed forms received by AHS are considered the legal record; all other copies can be securely destroyed.

Last Name	First Name
Job Title *(e.g. Physician, Analyst, Nurse, etc)*	Identification # *(For physicians-CPSA #)*
Phone	Email

Role *(submit your form to the office identified in brackets)*

☐ Employee of AHS/subsidiary *(Manager/Supervisor)*

☐ Medical Staff, Medical Students, Residents/Trainees (*Zone Medical Office)*

Indicate Primary Zone _____

☐ Volunteer *(Volunteer Resources Coordinator)*

☐ Researcher (*Repository Owner)*

☐ Student or Educator (*Educational Institution Liaison)*

☐ Board Member *(Board Office)*

☐ Midwives (*Chief Nursing Officer)*

It is required that you read and understand the above referenced policies and treat patient, personal or other AHS information as confidential. Confidentiality of information is governed by both AHS policy, provincial, and federal law.

You must sign this Agreement before AHS will grant access to AHS information or to an AHS owned or operated electronic system ("AHS System"). This Agreement explains the rules and expectations related to securing and protecting AHS information and systems. You may be required to comply with additional terms and conditions before accessing specific AHS Systems.

Agreement

Appropriate Collection, Use and Disclosure of Information

1. I shall only collect, access, use and disclose the minimum information necessary for the purpose of fulfilling my duties and responsibilities related to my role at AHS ("AHS Responsibilities").
2. I will not access information except as necessary for my AHS Responsibilities. I will not otherwise access information, including my own health information, or the information pertaining to: a family member, friend, colleague, or anyone who is not within my scope of my AHS Responsibilities. There are other procedures in place (including in Health Information Management) which would allow me or others to appropriately request access to health information.

Agreement (continued)

Appropriate Collection, Use and Disclosure of Information (cont'd)

3. I shall ensure that information I enter into an AHS System is complete and accurate to the best of my ability.
4. I shall dispose of any information I access from an AHS System (whether in electronic or paper form) in a secure manner as explained in AHS policies and procedures.
5. I shall use reasonable means to ensure that while I am accessing information on an AHS System it will not be viewed or obtained by unauthorized people (e.g. secure my computer, be discreet when viewing data).
6. I understand that AHS retains custody and control over all information contained in an AHS System as well as information in paper form.
7. I shall not collect, use, transmit or disclose any AHS information except as allowed by AHS policies and procedures.

System Security

8. I will keep any AHS System login information, such as my user password, confidential and will not share this login information with anyone else.
9. I am responsible for any use of any AHS System performed under my login information.
10. I will not leave my workstation unattended without logging out or securing my workstation or application.
11. I will not use or obtain another person's login information.
12. If I believe my login information may be known by another person I will immediately change my password and notify the AHS Information Risk Management Office.
13. I shall not download or install any application or program to an AHS System without the approval of the administrator for that particular AHS System.

Confidentiality Provisions

14. I shall take reasonable actions to keep all AHS information private and confidential and prevent the unauthorized collection, use and/or disclosure of all AHS information that I come into contact with.
15. I accept that the obligation to keep AHS information confidential continues even after my AHS responsibilities end.
16. If I become aware of a violation of a policy referenced above or a potential or actual breach of confidentiality, I will notify my Supervisor immediately. I will also notify the AHS Information & Privacy Office or Information Risk Management as soon as possible.

Audit and Sanctions

17. I understand and acknowledge that AHS conducts random audits of AHS Systems and may audit my use of any AHS System without notice.
18. I understand that AHS, in its sole discretion, may revoke or restrict my access to any AHS information or AHS System for any reason, with reference to AHS Policies, Bylaws or Agreements.
19. I acknowledge that I have read the policies referenced above and understand the consequences for a violation of those policies and/or this Agreement.

I accept the rules and expectations described in this agreement:

Name *(print)*	Signature	Date *(yyyy-Mon-dd)*