



Lively  
Technical  
College

**Patient Care Technician Program  
Application  
Packet 2026 - 2027**

# PATIENT CARE TECHNICIAN PROGRAM APPLICATION PACKET

## PROGRAM DESCRIPTION

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The Patient Care Technician Program (PCT) is designed to prepare students employment as advanced cross-trained certified nursing assistants and home health aides. This program offers a broad foundation of knowledge and skills, expanding the traditional role of the nursing assistant, for acute and long-term care settings along with home health; EKG performance and readings; phlebotomy; and rehabilitation assisting.

## PROGRAM OFFERINGS

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FALL - AUGUST

SPRING - JANUARY

## PROGRAM LENGTH

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The program consists of 600 clock hours.

## PROGRAM HOURS

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Fall Program & Spring Program

Full-time Days: Monday – Thursday 8:00 a.m. – 4:00 p.m.

Clinical hours and locations may vary, including weekends.

## PROGRAM LOCATION

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Lively Technical College (LTC)

Health Education Department, Building 15

500 North Appleyard Drive

Tallahassee, FL 32304

(850) 487-7449

**Note: Please consult another resource for more specific information like a Health Program Schedule of Start and End Dates or reach out to the Health Education Office at 850-487-7449 for details.**

*No person shall on the basis of sex, gender identity, marital status, sexual orientation, race, religion, ethnicity, national origin, age, color, pregnancy, disability, military status or genetic information be denied employment, receipt of services, access to or participation in school activities or programs if qualified to receive such services, or otherwise be discriminated against or placed in a hostile environment in any educational program or activity including those receiving federal financial assistance, except as provided by law.” No person shall deny equal access or a fair opportunity to meet to, or discriminate against, any group officially affiliated with the Boy Scouts of America, or any other youth group listed in Title 36 of the United States Code as a patriotic society.*

# HEALTH EDUCATION APPLICATION COVER SHEET/CHECKLIST

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Program: \_\_\_\_\_  Day  Night Program Date: \_\_\_\_\_

## STEP 1. REGISTER FOR LIVELY TECHNICAL COLLEGE

**COMPLETE THE LTC STUDENT ONLINE APPLICATION**

Apply at [www.livelytech.com](http://www.livelytech.com)

**MEET WITH ADMISSIONS ADVISOR**

Must bring:

- Two proofs of Florida Residency
- Official transcripts for High School/College/GED (For copy of GED go to [www.myged.com](http://www.myged.com))

**SKILLS ASSESSMENT TEST OFFICIAL RESULTS** (if needed)

**MEET WITH FINANCIAL AID**

Financial Aid is available based on eligibility.

Completed required enrollment process to LTC with Admissions. Advisor Initials: \_\_\_\_\_

## STEP 2. COMPLETE THE PROGRAM APPLICATION PACKET

**HEALTH EDUCATION STUDENT INFORMATION SHEET**

**THREE CURRENT REFERENCE LETTERS:**

- Two professional references (recent employers, former teachers, counselors, etc.)
- One personal reference (may not be family member)

**STUDENT HEALTH ASSESSMENT FORM** (Must be completed by Healthcare Provider)

**WRITING SAMPLE**

**RECEIPT OF PAYMENT FOR A LEVEL 2 CRIMINAL BACKGROUND TO LEON COUNTY SCHOOLS**

**VACCINATION ACKNOWLEDGMENT**

**LATE OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.**

OFFICE USE ONLY:

BACKGROUND RESULTS

APPROVE/ACCEPTANCE LETTER

ORIENTATION

## GENERAL REQUIREMENTS

Applicants seeking admission to the PCT Program must:

- Be at least 18 years of age at projected time of program completion.
- Have a high school diploma or equivalent.
- Pass random drug screenings throughout the program. Students with positive drug screen results will be withdrawn from the program.

To apply for acceptance into the PCT Program students must:

- **STEP 1 - COMPLETE THE LTC STUDENT ONLINE APPLICATION.** (This application is required for all LTC students) This application can be completed at: [www.livelytech.com](http://www.livelytech.com)
- **STEP 2 - MEET WITH ADMISSIONS ADVISOR-** Student Services will review your online enrollment information. You will need to provide:
  - Two proofs of Florida Residency
  - Official Transcripts for High School and College (if applicable). For copy of your GED transcript go to [www.myged.com](http://www.myged.com)
  - Academic Skills Test Official Results or exemption (see below for more information).
- **STEP 3 - MEET WITH FINANCIAL AID**  
– Meet with Financial Aid. They will check for all needed financial aid documents (ISIR, verification letter, etc.) Bring proof of any additional grants, scholarships, or waivers in order to receive your deferment. (If you are self-pay, you may skip this step.). Federal Pell Grant information is at [www.studentaid.gov](http://www.studentaid.gov). School code: **013997**

## COMPLETE THE PCT APPLICATION PACKET

The PCT Application Packet must include:

- **Health Education Student Information Sheet.**
- **A printed copy must be submitted with the application packet.**
- **Writing Sample**

- **Three current reference letters:**
  - Two professional references (recent employers, former teachers, counselors, etc.)
  - One personal reference (may not be family member)
- **Student Health Assessment Form signed by a healthcare provider.** Submit with the application packet. A physical is not required.
- **Receipt of payment for a Level 2 criminal background to Leon County Schools.** This must be completed prior to submitting the application, at the student's expense\*. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background. Cost \$95.
- **Electronic Fingerprinting**
- **Vaccination Acknowledgment**

**\*No refunds will be issued.**

**LATE OR INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.**

## TESTING INFORMATION – REQUIRED TESTS & SCORE

### Academic Skills Test (Academic Skills)

State Board Rule 6A-10.040, FAC states the following: “Students who are enrolled in a postsecondary vocational certificate program shall complete a basic skills examination.”

LTC admission policies require that all students that enroll in Workforce Education Certificate Programs of 450 hours or more must take the Academic Skills Assessment test or provide proof of acceptable forms of exemption from testing.

You may be exempt from the Academic Skills test if you:

- Possess a college degree at the associate in applied science level or higher.
- Demonstrate readiness for public postsecondary education pursuant to F.S. 1008.30 (See acceptable exemptions list in Admissions).

- Earned a standard Florida public high school diploma (Student entered 9th grade in the 2003-2004 school year or any year thereafter) or earned a GED in 2014 or any year thereafter.
- Student serves as an active duty member of any branch of the United States Armed Services
- Passed a state or national industry certification or licensure examination identified in State Board of Education rules and aligned to the career education program, which they enroll.
- Proof of exemption status is required. Please see an advisor for further details in Admissions.

**You must be in the Testing area by 8:00 am to start the test, Monday – Thursday by appointment only.** For more information, please contact The Testing Center: 850-487-7410

The academic skills test passing score for the PCT Program is a 10 in Reading, Language and Math. These scores are valid for two (2) years.

If you do not meet your exit scores, you will need to enroll in Academic Skills Building at a cost of \$30 per semester. The Academic Skills Building instructor evaluates your test scores and an individualized learning plan will be designed based on your Academic Skills results. Students work individually, at their own pace, and seek the assistance of an instructor when needed.

There is a \$25.00 fee for this exam. Applicants must go to the Registration window in Building 8 to pay for the exam then report to the Testing Center.

For more information, please contact The Testing Center: 850-487-7410

Regular Hours of Operation: Monday-Friday, 8:00am-4:00pm

## HEALTH REQUIREMENTS

Applicants are required to complete a Student Health Assessment Record by a Healthcare Provider (not more than 6 months old). If, after acceptance, a student's health status changes, further documentation may be required stating the student is physically able to continue the program. As stated on the Student Health Assessment Form, applicants are required to provide proof of the following current immunizations:

- Tetanus, within the past 10 years (Td or Tdap)
- MMR x2 (given on or after the applicant's first birthday).
- Hepatitis B series.
- Varivax x2
- PPD/Tuberculin skin test within past 12 months. PPD/Tuberculin skin testing is valid for one (1) year from date of administration. Students will be required to maintain current PPD/Tuberculin skin testing throughout the duration of the program. Students who test positive for tuberculosis must show proof of a negative chest x-ray taken within the past five years to satisfy this requirement.
- Seasonal Flu Vaccine (August-March) or Declination.
- COVID-19 Vaccines and Booster or Declination.

## CRIMINAL BACKGROUND CHECK/LIVESCAN FINGERPRINTING

All applicants must undergo a Level 2 criminal background through Leon County Schools and a Livescan service provider. In order to participate in the mandatory clinical practicum, as well as to obtain licensure, students must have a clear background. The cost for both is \$95.00.

## DRUG SCREENING

Drug screening is not required prior to admission into the program. However, all students must submit to and pass three random drug screenings after entering the PCT Program and prior to having access to the clinical health care facilities utilized in the Program. This is a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement demanded of all acute care facilities in Florida. Students who do not pass a random drug screening will be withdrawn from the program.

## DISABILITY SUPPORT SERVICES

If you have question regarding adult students with disabilities and accommodations, please contact LTC Admissions located in Building 9 or at 850-487- 7473.

## FINANCIAL AID

Financial Aid is available for this program based on eligibility. Qualifying students may be awarded a Federal Pell Grant based on their current FAFSA submission provided through the Federal Student Aid, U.S Department of Education. LTC does not provide loans. Third party loans and other personal financial arrangements are a personal decision of the student and not handled at LTC. Additionally, LTC accepts other funding options (Florida Prepaid, CareerSource, VA, etc.). The Financial Aid Office is located in Building 8, phone number 850-487-7421 or 850-487-7621 and/or via email at LTCFinAid@leonschools.net. Please direct all financial aid questions directly to their office.

## ACCEPTANCE INTO PROGRAM / REGISTRATION

LTC accepts applicants into all Health Education programs on a rolling admission basis. As we receive applications, potential students are scheduled for an interview with the Health Education Program Director or their assignee. Once an applicant has completed the interview, they will be notified of their admission status. Accepted applicants will be given an acceptance letter, which will allow them to register for the program they have applied to. LTC Health

Education programs may be closed prior to the posted application deadline date once that program has reached capacity. Questions regarding the application process should be directed to Health Education Program at 850-487-7449.

## ORIENTATION

After being accepted into the LTC PC T Program, applicants will be notified about attending a mandatory orientation. The date(s) and time(s) of this meeting will be given to all accepted students within their acceptance letter. For further information, please contact the Health Education Department at 850-487-7449.

## UNIFORMS

Upon acceptance students are expected to wear the specified program uniform (dark/smoke gray) whenever they are in the classroom, clinical simulation or clinical facility. Uniforms may be purchased in the LTC Bookstore in Building 8. Questions regarding proper attire and uniforms should be directed to the Health Education Department at 850-487-7449.

## LATE AND/OR INCOMPLETE PACKETS WILL NOT BE CONSIDERED.

The Florida Board of Nursing is responsible for protecting the public. In carrying out this responsibility, the Board of Nursing reserves the right to deny licensure to anyone who has been convicted of a crime other than minor traffic violations. Pursuant to Section 456.0635, Florida Statutes, the Florida Board of Nursing shall refuse to issue a license, certification or registration and shall refuse to admit a candidate for examination if the applicant has been:

- Convicted or plead guilty or nolo contendere (No Contest) to a felony violation regardless of adjudication of chapters 409, 817 or 893, Florida Statutes; or 21 U.S.C. ss. 801- 970 or 42 U.S.S. ss 1395-1396, unless the sentence and any probation or pleas ended more than 15 years prior to the application.
- Terminated for cause from Florida Medicaid Program (unless the applicant has been in good standing for the most recent five years).
- Terminated for cause by any other State Medicaid Program or the Medicare Program (unless the termination was at least 20 years prior to the date of the application and the applicant has been in good standing with the program for the most recent five years).

# Lively Health Education Student Information Sheet PERSONAL INFORMATION



Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone# \_\_\_\_\_

Health Education Program applying for:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Central Sterile Processing | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant    |
| <input type="checkbox"/> Patient Care Technician    | <input type="checkbox"/> Phlebotomy      | <input type="checkbox"/> Practical Nursing | <input type="checkbox"/> Professional Nursing |

## EDUCATION

High School \_\_\_\_\_ City/State \_\_\_\_\_

Highest grade completed \_\_\_\_\_ Year: \_\_\_\_\_ Choose one:  High School Diploma  GED

Previous Nursing School \_\_\_\_\_ City/State \_\_\_\_\_

College \_\_\_\_\_ Degree Awarded \_\_\_\_\_ City/State \_\_\_\_\_

Military \_\_\_\_\_

Have you attended any previous HED programs whether you completed or not?

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Central Sterile Processing | <input type="checkbox"/> Massage Therapy                              | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant    |
| <input type="checkbox"/> Patient Care Technician    | <input type="checkbox"/> Phlebotomy                                   | <input type="checkbox"/> Practical Nursing | <input type="checkbox"/> Professional Nursing |
| <input type="checkbox"/> LTC                        | <input type="checkbox"/> Name of Institution if other than LTC: _____ |  |   |

Program Attended \_\_\_\_\_ Date Attended \_\_\_\_\_

Certification Awarded  Yes  No Date the Certificate Awarded \_\_\_\_\_  
Proof required at time of application.

## EMPLOYMENT RECORD

Present \_\_\_\_\_ Title/Position \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ to \_\_\_\_\_

Previous \_\_\_\_\_ Title/Position \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ to \_\_\_\_\_

Previous \_\_\_\_\_ Title/Position \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ to \_\_\_\_\_

The information on this application is true and factual.

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

THIS FORM MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER

NAME (please print): \_\_\_\_\_  
Last First MI

DATE OF BIRTH: \_\_\_ / \_\_\_ / \_\_\_      Male \_\_\_      Female \_\_\_

1. MMR (Need proof of two MMR vaccines or one mumps, two measles, and one rubella. Any person born before 1/1/57 will need proof of rubella immunization or positive titer.)  
 Date of MMR #1: \_\_\_\_\_ Date of MMR #2: \_\_\_\_\_  
 OR  
 Antibody titers:  
 Mumps titer date: \_\_\_\_\_ Results:  Immunity       Not immune  
 Rubeola titer date: \_\_\_\_\_ Results:  Immunity       Not immune  
 Rubella titer date: \_\_\_\_\_ Results:  Immunity       Not immune  
 If not immune, will require MMR x2.

2. Tetanus (Td or Tdap with the last ten years):      Date: \_\_\_\_\_

3. Hepatitis B series:  
 \_\_\_\_\_  
 Hepatitis B #1 date      Hepatitis B #2 date      Hepatitis B #3 date  
 OR  
 Antibody titer date: \_\_\_\_\_ Results:  Immunity       Not immune

4. Varicella: **History of having Chicken Pox is not accepted.**  
 Date of 1st dose: \_\_\_\_\_ Date of 2nd Dose: \_\_\_\_\_  
 OR  
 Varicella titer date: \_\_\_\_\_ Results: \_\_\_\_\_ (Lab value)

5. PPD (TB Skin Test): \_\_\_\_\_ Date taken: \_\_\_\_\_  
 Results: \_\_\_\_\_ Positive \_\_\_ Negative \_\_\_  
 Chest x-ray, if positive PPD: \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_

6. Seasonal Flu Vaccine:      Date of Vaccine: \_\_\_\_\_ Injection Site: \_\_\_\_\_  
 (August - March)      Lot Number Expiration: \_\_\_\_\_ Examiner's Initials: \_\_\_\_\_

Verified by:

\_\_\_\_\_  
 Name of Physician's Office/Health Center

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Address of Office

\_\_\_\_\_  
 Date



## Vaccination Acknowledgment Form

Please check the box for the program in which you are seeking admission.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Central Sterile Processing Technician | <input type="checkbox"/> Medical Assisting | <input type="checkbox"/> Nursing Assistant |
| <input type="checkbox"/> Patient Care Technician               | <input type="checkbox"/> Phlebotomy        | <input type="checkbox"/> Practical Nursing |
| <input type="checkbox"/> Professional Nursing                  |  |  |

During these times, guidance and regulations around mandatory vaccines continue to change. As a clinical requirement, some of our contracted healthcare facilities may be authorized under law to require specific vaccinations. We are committed to closely monitoring the situation in order to communicate these changes to you in a timely manner.

By signing this agreement, I hereby acknowledge that I may be required to obtain a COVID vaccine at any point in the program to be in compliance with my clinical site requirements. I acknowledge that failure to be in compliance may result in withdrawal from my program.

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Student Signature

Date

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Print Name

Witness Signature

# Declination of Influenza Vaccination

My employer or affiliated health facility, \_\_\_\_\_, recommends that I receive influenza vaccination to protect myself, patients, staff, and others in the healthcare facility.

I acknowledge that I am aware of the following facts (please read and check each box):

- Influenza is a serious respiratory disease. Each year in the United States, influenza kills thousands of people and causes hundreds of thousands of hospitalizations.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect our staff and our facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before any influenza symptoms appear. During the time I shed the virus, I can transmit influenza to patients and staff in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread influenza to others. Symptoms that are mild or non-existent in me can cause serious illness and death in others.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- I understand that it is impossible to get influenza from influenza vaccine.
- The consequences of my refusal to be vaccinated could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers and all patients in this healthcare facility.

Despite these facts, I am choosing to decline influenza vaccination for the following reasons:

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- I understand that I can change my mind at any time and accept influenza vaccination.

I have read and fully understand the information on this declination form.

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

Name (PRINT) \_\_\_\_\_

Department \_\_\_\_\_

REFERENCE: CDC. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices – United States, . . . Access links to current ACIP recommendations at [www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html](http://www.cdc.gov/acip-recs/hcp/vaccine-specific/flu.html)









## LEVEL 2 BACKGROUND SCREENING INSTRUCTIONS

Level 2 screening standards (Fingerprints) return criminal history results on arrests (including juvenile) nationwide. Under Florida Statute 1012, persons with specified access require level 2 screening. Offences outlined in Florida State Statute 435.04 (crimes of moral turpitude) can be disqualifying when persons have been found guilty of or entered a plea of nolo contendere (no contest).

### Instructions:

1. Go to the Fingerprinting Office at the Leon County Schools District main office, located at **2757 W. Pensacola St., Building I** (to the right of the main district office). The hours for the Fingerprinting Office are: Monday-Friday, 8:00 am-5:00 pm - **Take this form with you.**
2. Submit payment for screening. Payment can be via credit card or money order.
3. **Obtain a receipt for the screening.**

Submit the receipt of the background screening along with the Health Education program application.

If your background screening does not come back "clear," you will be notified.

Additional information may be required.

## LEVEL 2 BACKGROUND SCREENING REQUEST FORM

The following individual needs to obtain a Level 2 Background Screening, per Florida Statute 1012:

### IMPORTANT:

**The ORI number for the screening is V37020031**

PLEASE PRINT

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DRIVER LICENSE NUMBER: \_\_\_\_\_

PHONE: \_\_\_\_\_

The above individual will be at Lively Technical College/Externship/  
Clinical Site for the following purpose:

\_\_\_ Student

Entity/Individual from Lively Technical College making this request:  
Lively Administration

Please submit print results to:

ATTENTION:

BJ Van Camp, CTE Director  
Lively Technical College  
500 North Appleyard Drive,  
Tallahassee, Florida 32304  
Fax: 850.487.7478



## Electronic Fingerprinting Form

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the livescan method.
- You can find an approved Livescan Service Provider at:  
<http://www.flhealthsource.gov/background-screening/> (Click on Livescan Service Providers)
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan Service Provider the Board office will not receive your background screening results.
- You must provide accurate demographic information to the Livescan Service Provider at the time your fingerprints are taken, including your Social Security number (SSN).

**The Board of Nursing ORI number is - EDOH4420Z**

- Typically background screening results submitted through a Livescan Service Provider are received by the Board within 24-72 hours of being processed.
- If you obtain your Livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Aliases: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Citizenship: \_\_\_\_\_ Race: \_\_\_\_\_  
(W-White/Latino; B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
(M=Male F=Female)

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Transaction Control Number (TCN#): \_\_\_\_\_

(This will be provided to you by the Livescan Service provider.)

**You will need to keep this form for your records.  
Do not send this form to the Board Office.**



**850-487-7555**

**[www.livelytech.com](http://www.livelytech.com)**

Main Campus:  
500 North Appleyard Drive  
Tallahassee, FL 32304

Airport Location:  
3290 Capital Circle SW  
Tallahassee, Florida 32310