

# HEALTHCARE SUPPORT SERVICES PROGRAM

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The **Healthcare Support Services Program** is intended to provide career preparation for students with an interest in pursuing a healthcare career. The program design enables students to gain the necessary knowledge, skills and behaviours they will need to participate in related cooperative education experiences in a **Hamilton Health Sciences** hospital under the guidance and supervision of a **Hamilton-Wentworth District School Board** teacher and **Hamilton Health Sciences** staff.

## To be eligible for this unique Grade 12 program, students must:

- a. have successfully completed a minimum of 20 credits (less than 20, consideration will be given on a per case basis)
- b. submit all required application information by the due date
- c. attend an interview session, if requested

## Please be advised of the following policies:

1. Selection of students will be based both on the availability of cooperative education placements and the suitability of candidates.
2. Students are not guaranteed acceptance to the program by submitting an application.
3. Remuneration will not occur in this program.
4. **Transportation to school, training centres and placements are the responsibility of the student.**
5. This will be a four (4)-credit, all day program consisting of two (2) academic credits (TPJ4M or TPJ4C or TPJ4E and SNC4M or SNC4E) and two (2) credits through cooperative education. (TPJ 4M/C/E8)
6. Students accepted into the program will be required to have a medical assessment and to produce documentation demonstrating they have received all necessary immunizations and medical screening tests e.g., two-step TB skin test, etc.
7. Students will be required to purchase suitable attire for the cooperative education placement.
8. In accordance with the Municipal Freedom of Information Act, 1989, students/parents will be asked to provide Social Insurance and Health Card information and consent to have images/photographs kept on file and used in future promotional/information materials and/or publications by the Hamilton-Wentworth District School Board and Hamilton Health Sciences.

## HEALTHCARE SUPPORT SERVICES PROGRAM

### Overview of the Program:

1. Students can apply for either semester. The program may run semester one and semester two, dependent on suitable applicants.
2. Students will spend five (5) days a week for the first two months at Juravinski Hospital for their in-class instruction by a **Hamilton-Wentworth District School Board** teacher.
3. Students will learn and practice clinical/support services skills in a simulated hospital ward setting at **Juravinski Hospital**, with full access to authentic medical equipment and resources.
4. Students will participate in a variety of cooperative education placements in Customer Support Services within the five hospitals at Hamilton Health Sciences (**Juravinski Hospital, Hamilton General Hospital, McMaster University Medical Centre and Children's Hospital, St. Peter's Hospital**).
5. Students will complete cooperative education placements as all day placements at the selected site under the supervision of a **Hamilton Health Sciences** Customer Support Services staff member.
6. On successful completion of the program, students will receive certification in Healthcare Support Services as endorsed by the **Hamilton-Wentworth District School Board** and **Hamilton Health Sciences**.
7. Students earn many of the required components for a Specialist High Skills Major designation.

### Healthcare Support Services Program

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ HWDSB e-mail: \_\_\_\_\_

OEN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Total Credits to date: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Social Insurance Number: \_\_\_\_\_

Home School \_\_\_\_\_ Counselors' Name (Please Print) \_\_\_\_\_

School Telephone Number: \_\_\_\_\_

Does the student have an IEP: Yes  No  SIP: Yes  No

I am applying for: Semester One  Semester Two  Either semester

#### CONSENT

In accordance with section 29(2) of the Municipal Freedom of Information and Protection of Individual Privacy Act, please be advised that the personal information obtained in this form is collected under the authority of the Education Act as amended. Questions regarding the collection of this information may be directed to the Director of Education: 20 Education Court, Hamilton, Ont. L8N 3L1 at 905-527-5092. All information will be kept confidential.

“I have read and understand all of the above conditions and hereby agree to provide the requested information. I consent to have my image/photograph and placement profiles kept on file, and used for presentations, promotional and/or informational brochures, posters, newsletters, newspaper articles, web pages, videos and advertisements for the HWDSB and/or Hamilton Health Sciences.”

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

#### APPLICATION PACKAGE **must** include:

- Student Information Pages
- Resume
- Student status sheet
- Teacher Reference (references will be contacted)

**APPLICATION DEADLINE: Semester 1 May 1st  
Semester 2 December 2nd**

Late applications may be considered if space permits.

Guidance Counselors please send the completed application package to:

Mrs. Nancy Godwaldt  
20 Education Court, Hamilton, ON L9A 0B9  
Fax: (289) 674-0409 Email: ngodwald@hwdsb.on.ca

## HEALTHCARE SUPPORT SERVICES PROGRAM

### Student Information

Please complete the following career-specific questions (use an extra sheet if necessary)

1. Why have you selected this program?

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2. Briefly describe what you know about this healthcare career.

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3. What qualities (attitudes, skills, knowledge, experience) do you possess that identify you as a suitable candidate for this program?

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4. How do you think you can benefit from participating in this program?

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5. What challenges will this program present to you?

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6. How does this program relate to your future career plans?

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## HEALTHCARE SUPPORT SERVICES PROGRAM

# TEACHER REFERENCE



Name of Student: \_\_\_\_\_ School: \_\_\_\_\_

Name of teacher recommending this student: \_\_\_\_\_

Course/s I have taught this student: \_\_\_\_\_

The students accepted into this program will be representing your school, the HWDSB, and themselves in a setting outside of a regular school (Juravinski Hospital). Students accepted into the program must have exhibited the maturity and work habits that will enable them to be successful in this program.

Please check off and/or comment on the following items:

**N** = Needs Improvement    **S** = Satisfactory    **G** = Good    **E** = Excellent

	<b>N</b>	<b>S</b>	<b>G</b>	<b>E</b>	<b>COMMENTS</b> (or more detailed information)
Attendance					
Punctuality					
Works Independently					
Teamwork					
Organization					
Work Habits					
Initiative					

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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