STUDENT CERTIFIED NURSING ASSISTANT APPLICATION
DETAILED INSTRUCTIONS

 PHYSICAL EXAMINATION REPORT INSTRUCTIONS:

The Physical Examination Report located at the end of this document must be completed by your healthcare provider. The form must be submitted to the Center for Continuing Studies office before being invited to register. The Robert Wood Johnson Health Center is a recommended and convenient local clinic for your immunizations but you may go to any hospital or doctor’s office. Many walk-in minute clinics do give PPD shots. All immunizations and medical testing required for admission to this course is performed at the student’s own expense and must be done within the past 12 months. PPD shots must be current during the time the student is enrolled in class.

Immunizations

- Hepatitis B – A series of three (3) vaccinations is highly recommended for healthcare professionals. If you have completed the series, the dates need to be indicated and a blood test (titer) is required to show immunity status. If you have not begun the series, you may do so now and we will accept you into the program. If you chose not to be immunized for Hepatitis B, you must sign a declination form. Please contact us if you need this form.

- Mantoux (PPD)

A current two (2) stage PPD is required for your initial health record. Copies of the PPD results must be submitted. For students who have received a BDG or have a positive PPD, a chest x-ray report must be submitted. If you have already been tested for PPD, a single stage PPD or chest x-ray must be submitted annually, while enrolled.

You will also need a CBC, Urinalysis and Drug Screening as well as your doctor’s signature stating that you are physically able to perform the duties assigned in the class and clinical settings.
STUDENT LIABILITY INSURANCE INSTRUCTIONS:

All students are required to purchase student liability insurance.

A copy of your certificate of insurance must be submitted to the Center for Continuing Studies Office before registration. You may purchase this insurance online at www.nso.com, 1-800-247-1500. It is not required that students purchase their insurance from NSO. You may find a comparable company, as long as it has the appropriate coverage for a Nursing Assistant/Aide. You need to purchase insurance at the appropriate rate in the state that you reside. The average cost is approximately $35.00 for the year.

BACKGROUND CHECK INSTRUCTIONS:

You will not be admitted to our program until your background check is completed and approved.

The Joint Commission of Accreditation of Healthcare Organizations (JCAHO), which accredits healthcare facilities across the country, has enforced background screening since September 2004 and has set requirements mandating that students in a healthcare field must now complete the same background check as hospital employees.

A background investigation must be completed prior to your clinical experience at Mercer County Community College. Students are responsible for payment of their background investigation, and American Databank must conduct the investigation. The basic cost is $15 and an additional $15 for each maiden name or alias. To initiate your background clearance, go to the website www.mercercollegecx.com and follow the step by step process. Please print American Databank's authorization release form and fax it into them to authorize the process: be sure to check the box that says CHHA so that your information is reported quickly to our office. Their phone number is 1-800-200-0853. The profile information you input will be sent directly to the school upon completion. If you would like a copy sent to you, you may indicate that when you apply.
The following search is required for students attending facilities for clinical instruction through Mercer County Community College:

- Criminal History Record Search (7 years)
- Maiden/Alias Names

If you do not have a credit card you may contact American Databank to arrange to pay via check or money order. Please note that this may delay your application several weeks.

This is what the online application looks like:
Applicant Information:

- Every applicant must print the Disclosure and Release Form, fill it out and fax to 1-303-373-1779.
- There is an additional $15 fee for each Maiden or Alias Name listed.
- Bold * lettering indicates required information.

<table>
<thead>
<tr>
<th>Applicant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Last Name:</td>
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<tr>
<td>Middle Name:</td>
</tr>
<tr>
<td>Maiden/Alias Names:</td>
</tr>
<tr>
<td>Only provide if used within the last 7 years.</td>
</tr>
<tr>
<td>Alias/maiden name 2:</td>
</tr>
<tr>
<td>Only provide if used within the last 7 years.</td>
</tr>
<tr>
<td>Alias/maiden name 3:</td>
</tr>
<tr>
<td>Only provide if used within the last 7 years.</td>
</tr>
<tr>
<td>SSN*:</td>
</tr>
<tr>
<td>Date of Birth*:</td>
</tr>
<tr>
<td>Phone Number*:</td>
</tr>
</tbody>
</table>
BACKGROUND CHECK ADDITIONAL INFORMATION:

All students will also be required to complete a MCCC criminal background check prior to beginning the Certified Home Health Aide course. You will need to undergo fingerprinting and an additional background check instituted by the Department of Health and Senior Services. **This will be done during class.**

An applicant whose criminal background check discloses a conviction or unresolved arrest for a crime or misdemeanor that could jeopardize the health, safety or welfare of any patient, employee, student or visitor may also be barred from entrance to the school.

If your MCCC background check is flagged, you will be required to provide a written statement indicating the specific details of each conviction you have on your criminal record, the outcome of any trial/hearing and what you have done since the offense to better yourself. Letters of reference may also be required. You are advised that if you are admitted to the program, MCCC cannot guarantee that you will be licensed by the New Jersey Department of Health and Senior Services pending their independent review of your criminal history. **If your application is under review you will not be admitted to the program until any background check issues are resolved.**

In order to take part in the educational program an applicant must not have been convicted of, or pled guilty to:

- Homicides
- Assaults
- Kidnapping or criminal coercion
- Sexual offenses
- Robbery
- Thefts, larceny and fraud
- Endangering the welfare statues
- Drug offense

Information on background check results and conditions may be located on page 2 in the New Jersey Nurse Aide & Personal Care Assistant Candidate Handbook which is distributed at the information session.

The individual presenting this form has been accepted into a Health Professions Program at Mercer County Community College. Nursing assistant students are required to meet the same health requirements mandated by the NJ Department of Health and JCAHO as employees of any health care facility.
CENTER FOR CONTINUING STUDIES
MERCER COUNTY COMMUNITY COLLEGE
HOME HEALTH AIDE PROGRAM APPLICATION FORM

NAME ___________________________________________ MCC ID NUMBER: ____________________________

ADDRESS ______________________________________________________________________________________

STREET __________________________________________________________________________ CITY __________

STATE __________ ZIP __________

HOME PHONE (____) ____________________ WORK PHONE (____) ____________________

CELL PHONE (____) ____________________ E-MAIL __________________________________________

DO YOU HOLD A COLLEGE DEGREE? NO ☐ YES ☐ IF YES, AS ☐ BS ☐ MS ☐ PhD ☐

COLLEGE ______________________________________________________________________________________

NAME ______________________________________________________________________________________

ADDRESS ______________________________________________________________________________________

CITY/STATE ____________________________________________________________________________________

PROGRAM OF STUDY __________________________ DATE OF GRADUATION ________ / DATES ATTENDED________

HIGH SCHOOL ____________________________________________________________________________________

NAME ______________________________________________________________________________________

ADDRESS ______________________________________________________________________________________

CITY/STATE ____________________________________________________________________________________

DATE OF GRADUATION ________ ARE YOU OVER 18 ________ MALE ☐ FEMALE ☐

EMERGENCY CONTACT ______________________________________________________________

NAME ______________________________________________________________________________________

RELATIONSHIP _________________________________________________________________________________

PHONE NUMBER __________________________________________________________

WORK EXPERIENCE (MOST RECENT FIRST OR ATTACH RESUME)

DATES EMPLOYED _______________________________________________________________________________

NAME OF EMPLOYER ______________________________________________________

POSITION HELD ______________________________________________________

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Certified Home Health Aide
Student Agreement

I, ____________________________, understand that my admission to the Certified Nursing Assistant program is provisional based upon the completion of the following.

<table>
<thead>
<tr>
<th>Initial</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am required to submit proof of a high school diploma, GED or college transcript by before registering</td>
<td></td>
</tr>
<tr>
<td>I am required to have all current laboratory tests and required shots and submit a medical release form signed by my physician before registering</td>
<td></td>
</tr>
<tr>
<td>I am required to provide proof of liability insurance for Certified Nursing Assistants and proof of personal health insurance before registering.</td>
<td></td>
</tr>
<tr>
<td>I understand that I am responsible to purchase the required uniform, shoes, equipment and textbook and workbook prior to the first day of the class. I understand that I must obtain a MCCC Student ID badge prior to the first day of clinical practice. Students who fail to purchase the required items will not be allowed to attend clinical and will be dismissed from the program.</td>
<td></td>
</tr>
<tr>
<td>I am informed of the requirement to undergo a criminal background check by Mercer County Community College for clearance to attend the clinical portion of this course and the additional NJ State requirement for a criminal background checks and fingerprinting prior to certification. A positive criminal history may preclude a student’s ability to complete clinical education and/or obtain certification from the State of NJ. Application to American Databank for the criminal background check must be initiated by the student and received by the college before the student is permitted to register. Please read attached addendum for additional information.</td>
<td></td>
</tr>
<tr>
<td>I understand that I will be admitted to the program and pay my registration only after my background check and application are completed and approved.</td>
<td></td>
</tr>
</tbody>
</table>

I have read and understand the requirements set within this document. I understand I will not be able to complete the C.H.H.A. program unless the above requirements have been met.

____________________________________
Student Signature – Date
The individual presenting this form has been accepted into a Health Professions Program at Mercer County Community College. Nursing assistant students are required to meet the same health requirements mandated by the NJ Department of Health and JCAHO as employees of any health care facility.

NAME: ___________________________           PROGRAM: Certified Home Health Aide

MCCC PERSONAL IDENTIFICATION NUMBER: ___________________

---

**IMMUNIZATIONS**

Tetanus/ Diphtheria booster (Must be within 10 yrs.)  Date __________________________

**Hepatitis B**

<table>
<thead>
<tr>
<th>Series</th>
<th>Dose 1 Date</th>
<th>Dose 2 Date</th>
<th>Dose 3 Date</th>
</tr>
</thead>
</table>

Screening/Titer Date* __________________________ Immune Non immune

**NOTE:** ONCE SERIES IS COMPLETED, TITER* MUST BE DRAWN AND RESULTS SUBMITTED. IF CLIENT IS NON-IMMUNE, SERIES MUST BE REPEATED. STUDENT WILL BE ACCEPTED AS LONG AS Hepatitis B SERIES IS INITIATED OR A DECLINATION FORM IS SUBMITTED.

*Quantitative test results required

---

**LABORATORIES**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Within Normal Limits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Screening</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**TWO STEP MANTOUX (PPD)**

#1 STEP ADMIN DATE ______________________ #1 STEP RESULTS ______________________

#2 STEP ADMIN DATE ______________________ #2 STEP RESULTS ______________________

➢ **NOTE:** IF POSITIVE OR CLIENT RECEIVED BCG, A CHEST X-RAY MUST BE TAKEN AT THIS TIME UNLESS ONE WAS PERFORMED WITHIN THE PAST TWO MONTHS. THE RADIOLOGY REPORT MUST BE SUBMITTED.

The tine or multiple puncture tests are not sufficient
### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Pulse:</th>
<th>Blood Pressure:</th>
<th>Height:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

#### Hearing
- Normal
- Abnormal
- Corrected

#### Vision
- Normal
- Abnormal
- Color Blind
- Corrected with Glasses

### ARE THERE ANY ABNORMALITIES IN THE FOLLOWING?

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
- EENT
- Cardiovascular
- Pulmonary
- Gastrointestinal
- Hernia
- Endocrine
- Musculoskeletal
- Neurological
- Genitourinary
- Emotional
- Physical Handicap

If yes, please explain


### PHYSICIAN’S STATEMENT

Upon review of the physical exam and lab results, I certify that this student is medically able to perform all clinical activities without restrictions.

MD/NP Signature: ____________________________ Date: ____________
Print Name: ____________________________ License #: ____________
Address: ____________________________
Telephone #: ____________________________