Certified Nurse Aide Program – Spring 2018

Thank you for your interest in the Certified Nurse Aide Program at Tunxis Community College. This program has been approved by the State Department of Public Health. Upon completion, graduates are eligible to be listed on the Connecticut Nurse Aide Registry. The 113-hour program is held over a 12-week period and offered days, evenings, and Saturdays. Each clinical is limited to eight students accepted on a first come, first served basis. Classroom instruction is held at the college; clinical groups are held at Ingraham Manor in Bristol.

Program Requirements:

You must be at least 17 years old and complete the following:

- Fill out the enclosed CNA application, Questionnaire, Physical Verification Form & Health Form *(completed health form with documentation due by **March 1**).*
- Mail or bring the application forms along with a non-refundable $35 administrative fee (credit/debit card, check or money order payable to TCC – **no cash** please), to Continuing Education, located in the library building 700, at Tunxis Community College, 271 Scott Swamp Road, Farmington, CT 06032.

Acceptance:

Your application will be forwarded to the Allied Health Coordinator for consideration. Upon acceptance, you will be notified in writing and given further instructions to complete your enrollment.

Once you are accepted, tuition must be paid to the College within five business days of notification. Students will not be allowed into class until they have started a payment plan or paid the full course tuition.

Refunds may be obtained ONLY if your written withdrawal is received by the Continuing Education Office three business days prior to the Mandatory Orientation session.

Uniform:

Uniforms are to be worn at all times (both classroom and clinical) except the Mandatory Orientation Session. See Associated Cost sheet (page 3) for details.

Health Form:

Each applicant to the program must submit a health form. No one can be permitted to participate in the clinical portion without these requirements. **The original form must be submitted to the Allied Health Coordinator and cannot be faxed. Please do not submit the health form until it is fully completed.**

NOTE: This form must be in place by the deadline date in order for a student to be eligible for the lab and clinical experience.

Health form due by: Thursday, March 1.

Students who successfully complete the program are eligible to receive college credit through the Connecticut Credit Assessment Program administered by Charter Oak State College. For information visit http://www.charteroak.edu/current/programs/creditregistry.cfm

Please be advised that if you have been convicted of a felony or misdemeanor, you may not be eligible for clinical experiences, internships, externships or certifications associated with certain Allied Health courses or programs. Those with previous convictions may also find it difficult to secure employment within a health care agency or institution.

For more information, please call the Continuing Education Office at (860) 773-1450.

COSTS ASSOCIATED WITH THE TUNXIS CNA PROGRAM – SPRING 2018

Fees Due Directly to Tunxis Community College:

$35 non-refundable administrative fee
payable to TCC at the time of registration

$950 tuition – with Day or Evening Clinical ➡
$999 tuition – with Saturday Clinical ➡
Tuition includes malpractice insurance and state examination fee

Payment Plan Option:

1st Payment**	2nd due March 22
$500	$475
$500	$524

***Includes a $25 installment fee.*

Visa, MasterCard, Discover, Amex, money order or check; paid in the Continuing Education Office

Students using the payment plan should notify the Continuing Education office (Bldg 700 or 860.773.1448) before setting up their payment plan in person at the Business Office (Founders Hall).

Costs Associated With the Program but Not Payable to TCC:

$55 Connecticut Nurse Aide Registry Fee
Student receives paperwork upon successful completion of the certification exam that requires this fee.
Sent by the student with one of the following payment methods (**no cash or personal checks**):

- Money Order payable to Prometric
- MasterCard, Visa, or Discover credit or debit card

$125 (estimated) textbook
payable to Follett Bookstore at Tunxis

$175 (estimated) for uniform: **navy blue** scrub top and pants
white sneakers or nurse's shoes
watch with a second hand

This program is not eligible for federal financial aid.

Funding options may be available through CT Works (WIOA) and the CT Department of Labor. To see if you qualify, call New Britain CT Works at 860.899.3500.

For a complete listing of services and locations, please visit: **ctdol.state.ct.us**

TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program

WITH DAY CLINICAL
February 8 – May 7, 2018

MANDATORY ORIENTATION: Thursday, February 8, 10AM-1PM in Room 6-173

Lecture Dates – Room 6-173 **11 Mondays, 1 Tuesday, 6-9PM**	**Lab Dates – Room 202** **Tuesdays or Fridays 7:30AM-1PM, or Sat. 8AM-1:30PM**
February 12	Feb. 13 or 16 or 17
February 20 (**Tuesday**)	Feb. 20 or 23 or 24
February 26 **Quiz 1**	Feb. 27 or March 2 or 3
March 5	March 6 or 9 or 10
March 12	March 13 or 16 or 17 **Midterm Lab Evaluation**
	Clinical Dates – 7:30AM-2PM
March 19 **Midterm Exam**	March 20 or 23 or 24
March 26	March 27 or **March 29 (Th 4-10:30pm)** or March 31
April 2 **Quiz 2**	April 3 or 6 or 7
April 9 **Quiz 3**	April 10 or 13 or 14
April 16 **Medical Abbreviations Quiz**	April 17 or 20 or 21
April 23	April 24 or 27 or 28
April 30 **Exam/State Written Certification Exam**	May 1 or 4 or *5– ***8AM-230PM** **Final Clinical Evaluation - Tunxis**

Monday, May 7: **State Certification Skills Examination**

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory

TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program

WITH EVENING CLINICAL
February 8 – May 7, 2018

MANDATORY ORIENTATION: Thursday, February 8, 10AM-1PM in Room 6-173

Lecture Dates – Room 6-173 11 Mondays, 1 Tuesday 6-9PM	Lab Dates – Room 202 Wednesdays or Thursdays 4-9:30PM
February 12	Feb. 14 or 15
February 20 (**Tuesday**)	Feb. 21 or 22
February 26 **Quiz 1**	Feb. 28 or March 1
March 5	March 7 or 8
March 12	March 14 or 15 **Midterm Lab Evaluation**
	Clinical Dates – 4-10:30PM
March 19 **Midterm Exam**	March 21 or 22
March 26	March 28 or 29
April 2 **Quiz 2**	April 4 or 5
April 9 **Quiz 3**	April 11 or 12
April 16 **Medical Abbreviations Quiz**	April 18 or 19
April 23	April 25 or 26
April 30 **Exam/State Written Certification Exam**	May 2 or 3 **Final Clinical Evaluation - Tunxis**

Monday, May 7: **State Certification Skills Examination**

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory

BANNER ID ________________________________ FEE PAID ________________________ CC ____________ CRN _____________________________

TUNXIS COMMUNITY COLLEGE

CERTIFIED NURSE AIDE PROGRAM 2018

☐ **Spring** ☐ **Summer** ☐ **Fall**

Clinical (check only one): **DAY:** ☐ Tuesday ☐ Friday ☐ Saturday

EVE: ☐ Wednesday ☐ Thursday

Name____ Date of Birth__________________

last first middle

Home Address____

street city state zip

E-mail Address____

Phone____________________ Work / Cell Phone____________________ SSN#_________________________

Gender: ☐ Male ☐ Female Primary Language ___________________________________

Ethnic/Racial (optional): ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Emergency Contact Name____ Phone #____________________

Are you a U.S. Citizen? ☐ Yes ☐ No If no, are you an alien who has the legal right to work? ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor? ☐ No ☐ Yes—briefly explain below.

*An arrest record could affect your ability to obtain employment as a CNA.

EDUCATIONAL INFORMATION

High School or GED Certification____

(school attended and year graduated or certified)

College or University____

(school attended, degree and year graduated)

Are you competent in reading comprehension and able to do math computation? ☐ Yes ☐ No

If no, please explain.

Briefly list employment history below.

PAYMENT INFORMATION

Tuition Payment Source ☐ Self ☐ Agency (Agency name, caseworker and phone number **required** below):

____

Application Fee Paid By: Check Number ____________ Money Order _____________________ ☐ Agency

MasterCard/Visa/Discover: ____ Exp. Date _______________

I understand the refund policy means I must contact the CE office three business days prior to the start of class and that no refunds will be issued after that time under any circumstances.

The information provided on this registration form is complete and accurate.

Signed____ Date_______________________

Tunxis Community College
271 Scott Swamp Road
Farmington, Connecticut 06032

CERTIFIED NURSE AIDE PROGRAM
PHYSICAL VERIFICATION FORM

Name of Student____

Address____

City______________________ ***State***__________ ***Zip Code***______________

Check the appropriate answer.
Please answer as honestly as possible. If yes is checked, please provide a brief explanation.

Allergies?	☐ **Yes**	☐ **No**
Pregnant?	☐ **Yes**	☐ **No**
On medication?	☐ **Yes**	☐ **No**
Mental health concerns?	☐ **Yes**	☐ **No**
Hearing problems?	☐ **Yes**	☐ **No**
Back problems?	☐ **Yes**	☐ **No**
Knee problems?	☐ **Yes**	☐ **No**
Recent surgeries?	☐ **Yes**	☐ **No**
Lifting restrictions? *(i.e. arthritis, injury, surgeries, etc.)*	☐ **Yes**	☐ **No**
Latex allergy?	☐ **Yes**	☐ **No**

Please list any medications here:

____

____

____

If you are pregnant, have any back problems/lifting restrictions, or a medical condition that is being monitored by a physician, a form will be provided by the College that must be completed by your physician along with your signature.

Please list any other conditions that you feel may present a risk for you or that your Instructor should be aware of to protect your well-being and safety.

____

____

____

Student Signature ______________________________ ***Date:***__________________

TUNXIS COMMUNITY COLLEGE
CERTIFIED NURSE AIDE PROGRAM

Name: ____

Do you have transportation? ☐ **Yes** ☐ **No**

Tell us about yourself.

What is your primary language? ________________________________
(Students who are ESL are encouraged to meet with the Allied Health Coordinator to discuss if their language may impede them from completing this course. You should be English proficient.)

List five qualities you possess that make you a good candidate for the program:

Do you know what being a C.N.A. entails? Briefly describe.

Why do you want to take this course?

How do you feel about working with the elderly?

How can Tunxis be assured that you will be committed to the program?

Do you have any physical limitations? If yes, please describe.

What would you do if you saw or heard an employee physically or verbally abusing a resident?

Have you ever been arrested? If yes, please explain.

What are your career goals?

How did you hear about this course?

Student Signature: _______________________________________Date: ____________

Tunxis Community College
Non-Credit Allied Health Programs

Health Form Requirements Checklist

Please use this checklist to guide you through the process of submitting an accurate and fully-completed health form.

Fill out Page 1

Check which program you're in — **Check_____**

Last 4 digits of your Social Security Number — **Check _____**

Under personal history, if you check yes, please explain. — **Check_____**

Banner ID# on EVERY PAGE SUBMITTED — **Check _____**

Page 2 – must be filled out by your physician, PA or APRN

All students are required to provide either proof of immunization or laboratory results of immunity. TITERS chosen for proof of immunization MUST BE POSITIVE and the LABORATORY REPORT MUST ACCOMPANY THE HEALTH FORM.

1. **MMR – dates of immunization or blood titer that shows immunity written on health form – attach document to show proof.** **Check _____**
2. **Polio – date(s) of immunization or blood titers that show immunity written on health form - attach document to show proof.** **Check _____**
3. **Chickenpox - dates of immunization, date of illness, or lab report that shows immunity written on the health form – attach document to show proof.** **Check _____**
4. **Tetanus booster – must be within the last 10 years, written on health form, attach proof of injection to the health form.** **Check _____**
5. **Flu vaccine (spring and fall applicants only) - date of vaccine written on the health form.**
   Check _______ **If declination, your health care provider must provide a note.**
   Attach document to show proof.
6. **Hepatitis B series - date(s) of injection or lab report written on the health form.** **Check _____**
   If a student hasn't received all 3 injections or refuses the series, a Hepatitis B waiver form (included in application packet) must be signed. Attach document to show proof. **Check _____**
7. **Tuberculin Test/PPD (Mantoux or QF-G) – date given, date read, and results written on the health form. Attach document to show proof.**
   Check _____
   A positive PPD or previous inoculation of BCG, must be accompanied by a chest x-ray with the appropriate follow-up. **Check _____**

(OVER)

Health Form Requirements (continued)

Physical Examination- All areas must be filled out in this section. Heart rate and Blood Pressure must be done. Nothing can be deferred. **Check _____**

A Urinalysis and Hematocrit or Hemoglobin must be documented with a number on the health form. Attach document to show proof.

Check ______

Date, Examining MD, PA, or APRN's signature must be completed along with the address completely filled out and a phone number. **Check _____**

Submit to the classroom instructor or Allied Health Coordinator Cheryl Conaty, R.N. (Room 6-216).

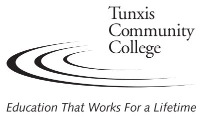
****Please make sure the entire health form is completed before submitting it.****

****Make a copy of your health form for your own personal records before handing it in.****

****Please do not staple forms together; paper clip them or use an envelope.****

Thank You.
Cheryl Conaty, RN
Allied Health Coordinator
Tunxis Community College
Continuing Education and Workforce Development
860-773-1453

STUDENT HEALTH FORM



Board of Regents for Higher Education

TUNXIS COMMUNITY COLLEGE, Attention: Cheryl Conaty, RN
271 Scott Swamp Road • Farmington, Connecticut 06032-3187

Banner ID: ____________

☐ **MAA**
☐ **MA**
☐ **CNA**
☐ **PHLEBOTOMY**

APPLICANT: Please print. Complete this side.
EXAMINING PHYSICIAN: Please print. Complete reverse side ASAP and return to address above.

APPLICANT

Name (last, first, middle) | Social Security #

Permanent Home Address (number & street, city or town, state, zip code) | Telephone # (include area code)

Sex: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date of Birth (month, day, year)

IN CASE OF EMERGENCY

Name (last, first, middle) | Relationship

Address (number & street, city or town, state, zip code) | Telephone # (include area code)

FAMILY HISTORY

Has any family member ever had the following:

☐ CANCER ☐ TUBERCULOSIS ☐ DIABETES ☐ ALLERGY OR ASTHMA ☐ EPILEPSY OR CONVULSIONS ☐ STROKE
☐ HEART DISEASE ☐ NERVOUS OR MENTAL ILLNESS ☐ MIGRAINE HEADACHES ☐ HIGH BLOOD PRESSURE

PERSONAL HISTORY

Have you ever had:	YES	NO		Have you ever had:	YES	NO	Have you ever had:	YES	NO
1. MEASLES			ITEMS 6-15	6. RHEUMATIC FEVER			11. CONVULSIONS		
2. MUMPS			*All "Yes" answers must be explained below.*	7. HEART DISEASE			12. HIGH BLOOD PRESSURE		
3. CHICKEN POX				8. HEART MURMUR			13. ALLERGIES		
4. GERMAN MEASLES				9. DIABETES			14. FAINTING SPELLS		
5. WHOOPING COUGH				10. TUBERCULOSIS			15. HEPATITIS		

QUESTION	YES	NO	If "YES," please explain:
1. Have you ever had any operations and/or significant injuries?			
2. Do you have any physical impairment? (eg., paralysis, loss of hearing, vision)			
3. Have you had any emotional problems requiring treatment?			
4. Do you take any medications regularly?			
5. Have you reacted unfavorably to any medication? (eg., penicillin, aspirin)			
6. Has your physical activity ever been limited?			

SIGNATURE(S)

Date | Student's Signature (if under the age of 18, parent or guardian must also sign)

PERMISSION TO TREAT MINOR INJURY OR ILLNESS

I hereby grant permission to the medical staff of the college to render or secure proper treatment for my daughter, son or ward (named above). It is my understanding that I will be notified in case of any illness or injury of major proportion. In addition, I grant permission to the college physician to hospitalize this student in case of a surgical emergency requiring the administration of anaesthesia provided that the physician is unable to communicate with me and that, in his/her judgement, delay might endanger the life of the student.

Date | Parent's or Guardian's Signature

THIS SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY

IMMUNIZATION HISTORY

ALL students are required to provide proof of either immunization or laboratory results of immunity. **TITERS** chosen for proof of immunization **MUST BE POSITIVE** and the **LABORATORY REPORT MUST ACCOMPANY THIS FORM**.

MEASLES 1st dose: ______________________ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday & after Jan. l, 1969

MEASLES 2nd dose: ______________________
date/given after Jan. 1, 1980

MUMPS: ______________________ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday

RUBELLA: ______________________ or Titer Immune? ❑ YES ❑ NO
date/given on or after 1st birthday

POLIO: ______________________ or Titer Immune? ❑ YES ❑ NO
date(s) of immunization

VARICELLA (Chicken Pox): ______________________ or Titer Immune? ❑ YES ❑ NO
date(s) of immunization

Td (TETANUS booster): ______________________
date/must have been given within the last 10 years

IMPORTANT!
Attach lab reports or immunization records for everything listed.

FLU VACCINE (spring and fall applicants only) ______________
date given

HEPATITIS B SERIES: ______________ ______________ ______________ Risk Form______________
date/1st dose date/2nd dose date/3rd dose intial

***TUBERCULIN TEST/PPD** (Mantoux or QFT-G): ______________ ______________ ______________
date given date read results

PHYSICAL EXAMINATION

HEIGHT	WEIGHT	COMMENTS and RECOMMENDATIONS		
EYES	VISION (R)	(L)	CORRECTION (R)	(L)
EARS	DRUMS	HEARING (R)	(L)	
NASOPHARYNX	SEPTUM	TONSILS		
TEETH	OCCLUSION	CARIES	GINGIVITIS	
NECK	CERVICAL NODES	THYROID		
CHEST	BREASTS	LUNGS		
	HEART (Rate)	(Rhythm)	(Murmurs)	(Blood Pressure)
ABDOMEN	LIVER	SPLEEN		HERNIA
SKELETAL	SPINE	JOINTS	FEET	
CNS	REFLEXES			
LABORATORY	URINALYSIS ***(Lab Reports Required)***	HEMATOCRIT OR HEMOGLOBIN ***(Lab Reports Required)***		

I believe this student is able to participate in a full academic and clinical program (unless otherwise noted above).

DATE	EXAMINING PHYSICIAN'S SIGNATURE M.D.	ADDRESS	TELEPHONE

For Office Use Only

BANNER ID @_________________

HEPATITIS B RISK FORM

I understand that due to my potential exposure to blood, body fluids and other potential infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that because I have either waived or not completed the Hepatitis B vaccination series, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I understand that if I experience an exposure to blood, body fluids or other infectious materials, I must notify my preceptor and/or instructor immediately. I will be directed to the Emergency Department where I will be offered the Hepatitis B virus immune globulin (HBIG), an injection(s). This injection provides temporary passive immunity from Hepatitis B. I will need to continue or start the Hepatitis B vaccination series.

By my signature below I acknowledge understanding that I (the student) am solely responsible for payment of all services, injections, vaccinations and other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have not completed the Hepatitis B vaccination series. I further understand that the College, its employees and clinical sites, will not be responsible for any services, injections, vaccinations or other costs associated with my exposure to blood, bodily fluids or other infectious materials while in the Program even though I have waived or not completed the Hepatitis B vaccination series.

I have received information about Hepatitis B and the risks of exposure to blood, body fluids and other potential infectious materials and my responsibility in reporting any incident of possible exposure.

____

Student's name – please print

____ __________________

Student's signature Date