

Merced College

Nurse Assistant Training Program

Check-Off Form

Name _____ MC Student I.D. # _____

Language most spoken at home* _____ Other language(s) spoken (if applicable)* _____

Ethnicity/ies* _____ *All items listed are required. *These responses are collected for grant purposes.*

Attention: Upon verification of your Nurse Assistant Program documents, you will be issued a registration voucher (space permitting). You will not be able to register in the ALLH-63 course without the voucher.

All documents listed below must be submitted at the time you apply, no exceptions. You must provide your own copies.

Please submit the documents in this order:

- Apply for College Admission.** Complete appropriate registration procedures and obtain a Student I.D. card. Further Registration information is available online: <https://www.mccd.edu> – Select the “Enroll” feature, then follow the steps provided.
High School Students – You must be at least 16 years old and a junior in high school in order to take this course. If your application is accepted, you may need to submit a k-12 form. Please talk with your high school counselor for more information.
- Nurse Assistant Check-Off Form (This Form)**
- Three (3) copies of the Nurse Assistant Initial Application - CDPH 283 B form** (see Table of Contents) - The form is located online: www.cdph.ca.gov. Follow instructions provided in the Nurse Assistant Orientation Video. Always use the most current form on the website.
*All students are required to be fingerprinted and possess a **current California ID or Driver’s License**. Fingerprinting may take place on the day you apply or on a separate date, should your application be accepted. Further information will be provided at the time you apply.*
- Health Evaluation** (See Table of Contents). This needs to be completed within 6 months of class start date – Example: If you are taking the Spring class which starts in January, your health evaluation would be completed between July and the application date.
- COPY of negative TB skin test or QuantiFERON-TB (QFT) blood test. If positive, a negative chest x-ray is needed.** This needs to be completed within 6 months of class start date – Example: If you are taking the Fall class which starts in August, your health evaluation would be completed between February and the application date.
- COPY of CPR card for the BLS Provider, Healthcare Provider or Professional Rescuer - certification must not expire the semester you are in the program.** The American Heart Association (AHA) name/logo must be printed on your CPR card/certificate.
- Flu (Influenza) Vaccine** - The flu vaccine is seasonal. Spring - required at time of application; Summer - not required; Fall - required once it becomes available, usually around September
- COVID-19 Vaccine/Booster** - Must have at least 1st vaccine at time of application. Subsequent doses will need to be submitted as you become due for them. Follow the current guidelines provided by the Centers for Disease Control and Prevention (CDC) for obtaining additional doses. Weekly testing may be required in program.

Having read all of the Merced College Nurse Assistant Training Program Student Handbook with care, I both understand and accept the responsibilities of my role as a Nurse Assistant student at Merced College.

Signature _____

Date _____

EXAMPLE for Merced Campus

State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:

California Department of Public Health (CDPH)
Licensing and Certification Division (L&C)
Healthcare Workforce Branch (HWB)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

Must be typed.

Print 3 copies of this form!

(Pages 1 & 2 ONLY, page 3 is an instruction sheet. We do not need you to print/submit that page.)

CERTIFIED NURSE ASSISTANT (CNA) INITIAL APPLICATION (See instructions on the reverse)

SECTION I (REQUIRED)

TYPE OF REQUEST

- Check here if you are enrolling in a **CNA** training program (complete sections I, II, III, IV, and V)
- Check here if you are requesting **RECONSIDERATION** for a previously revoked/denied certificate (complete sections I, II, III and V)

SECTION II (REQUIRED)

Last Name Sample Person	Name entered must match name on ID/DL EXACTLY.	First Name Merced	MI B.	Sex <input checked="" type="radio"/> Male <input type="radio"/> Female
Public Address (Required) – <i>Subject to Public Records Act Request release*</i> 1234 Merced St.		City Any Town	State CA	Zip Code 95348
Confidential Address (Required)- <i>(For CDPH Use only. If left blank all departmental mail will be sent to the address above)</i>		City	State	Zip Code
Date of Birth 02/29/00 <small>(mm/dd/yy)</small>	Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) 1 2 3 - 4 5 - 6 7 8 9 <small>**If you use an invalid SSN, your application process may be delayed</small>	Driver's License /State ID Number Number: A1234567 State: CA		

Phone Number *** **(209)999-9999**

By checking this box, you agree to receive text messages from the California Department of Public Health (CDPH) for reminders and notifications regarding your application and/or certification. You may receive up to 5 messages per month. Message and data rates may apply. By checking this box, you agree to the Terms and Conditions and Privacy Policy. Reply "STOP" to opt-out, and "HELP" for help.

Email Address***
mercedsampleperson@yahoo.com

SECTION III (REQUIRED)

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7).

Yes No

If yes, list conviction: _____

Court of conviction: _____ Date: _____

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?

Yes No

Type of License/Certificate: _____

License/Certificate Number: _____

Type of Action: _____

Check one box for each question.

IF yes, fill in the blanks.

SECTION IV (IF APPLICABLE)

Address must be filled in EXACTLY as shown below.

Name of school or facility where you received/will receive the CNA training

Merced College

Telephone Number

(209)384-6000

Mailing Address (Number Street or P.O Box number)

3600 M Street

City

Merced

State

CA

Zip Code

95348

California Training Program ID Number for **CNA**
(Required) CNA: **LEAVE BLANK**

Beginning Date of Training

LEAVE BLANK

(mm/dd/yy)

End Date of Training

LEAVE BLANK

(mm/dd/yy)

SECTION V (REQUIRED)

I certify under penalty and perjury under the applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application. I acknowledge that signing this document through electronic means shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.

LEAVE BLANK

Signature of Applicant

LEAVE BLANK

Date

SECTION VI: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (only applies to students that have recently completed a CNA Training Program in CA.

LEAVE BLANK

Printed Name

LEAVE BLANK

LEAVE BLANK

Title

LEAVE BLANK

Signature

Date

FOR VENDOR USE ONLY

It is YOUR responsibility to enter your information correctly on this form.

You should double and triple-check all information before submitting.

To complete this form, please visit www.cdph.ca.gov and search for "cdph283b"

EXAMPLE for Los Banos Campus

State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:

California Department of Public Health (CDPH)
Licensing and Certification Division (L&C)
Healthcare Workforce Branch (HWB)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

Must be typed.

**Print 3 copies of
this form!**

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an instruction sheet. We do not
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CERTIFIED NURSE ASSISTANT (CNA) INITIAL APPLICATION

(See instructions on the reverse)

SECTION I (REQUIRED)

TYPE OF REQUEST

- Check here if you are enrolling in a **CNA** training program (**complete sections I, II, III, IV, and V**)
 Check here if you are requesting **RECONSIDERATION** for a **previously revoked/denied** certificate
(**complete sections I, II, III and V**)

SECTION II (REQUIRED)

Last Name Sample Person		First Name Los Banos		MI B.	Sex <input checked="" type="radio"/> Male <input type="radio"/> Female
Public Address (Required) – <i>Subject to Public Records Act Request release*</i> 1234 Los Banos St.		City Any Town	State CA	Zip Code 93635	
Confidential Address (Required)- <i>(For CDPH Use only. If left blank all departmental mail will be sent to the address above)</i>		City	State	Zip Code	
Date of Birth 02/29/00 <small>(mm/dd/yy)</small>	Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) 9 8 7 - 6 5 - 4 3 2 1 <small>**If you use an invalid SSN, your application process may be delayed</small>	Driver's License /State ID Number Number: A7654321 State: CA			
Phone Number *** (209) 777-7777			Email Address*** losbanosampleperson@yahoo.com		
<input checked="" type="checkbox"/> By checking this box, you agree to receive text messages from the California Department of Public Health (CDPH) for reminders and notifications regarding your application and/or certification. You may receive up to 5 messages per month. Message and data rates may apply. By checking this box, you agree to the Terms and Conditions and Privacy Policy. Reply "STOP" to opt-out, and "HELP" for help.					

SECTION III (REQUIRED)

- 1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7).
 Yes No
 If yes, list conviction: _____
 Court of conviction: _____ Date: _____
- 2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
 Yes No
 Type of License/Certificate: _____
 License/Certificate Number: _____
 Type of Action: _____
- Check one box for each question.**

IF yes, fill in the blanks.

SECTION IV (IF APPLICABLE) Address must be filled in **EXACTLY** as shown below.

Name of school or facility where you received/will receive the CNA training Merced College - Los Banos Campus			Telephone Number (209)384-6000
Mailing Address (Number Street or P.O Box number) 22240 Highway 152	City Los Banos	State CA	Zip Code 93635
California Training Program ID Number for CNA (Required) CNA: LEAVE BLANK	Beginning Date of Training LEAVE BLANK <i>(mm/dd/yy)</i>	End Date of Training LEAVE BLANK <i>(mm/dd/yy)</i>	

SECTION V (REQUIRED)

I certify under penalty and perjury under the applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application. I acknowledge that signing this document through electronic means shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.

LEAVE BLANK LEAVE BLANK
 Signature of Applicant Date

SECTION VI: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (only applies to students that have recently completed a CNA Training Program in CA. <u>LEAVE BLANK</u> <u>LEAVE BLANK</u> Printed Name Title <u>LEAVE BLANK</u> <u>LEAVE BLANK</u> Signature Date	FOR VENDOR USE ONLY
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It is YOUR responsibility to enter your information correctly on this form.
You should double and triple-check all information before submitting.



Merced College
Allied Health
Physical Health Evaluation

Name	Date of Birth
Address, City, State, Zip	
Email Address	Phone

To be filled out by Health Care Practitioner, Physician Assistant, or Nurse Practitioner

For the student’s safety it is important to identify any family and/or personal history of current/past medical problems that would affect the student’s ability to participate fully in an Allied Health Program. ***The CNA, LVN, RN, RT and SONO Programs require the student to be able to stand, bend, perform heavy lifting, and twist frequently in providing care to patients during procedures. Additionally, the student must be able to make rapid, sound decisions related to patient safety.***

Vital Signs: Temp. _____ Pulse _____ Resp _____ BP _____

Vision: R _____ L _____ Hearing: R _____ L _____

Heart: _____ Lungs: _____

Back Injuries/Deformities: _____

ABD: _____

Comments: _____

By signing below, I CONFIRM this patient’s History AND Physical Condition adequate for them to fully participate in the Allied Health Program.		
<p style="text-align: center;">_____</p> <p style="text-align: center;">Date</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Health Care Professional</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Facility Stamp OR Attach Provider Business Card</p>

TB Testing & Flu (Influenza) Vaccine

TB:

Students must have a TB skin test or QuantiFERON-TB (QFT) blood test (**within six months of the start of class**) or negative chest x-ray. These must be completed annually while in an Allied Health program.

Flu (Influenza) Vaccine:

The flu vaccine is seasonal. Spring - required at time of application; Summer - not required; Fall - required once it becomes available, usually around September

Registered Merced College Students -

Student Health Services provides free TB testing & flu vaccinations to **current** Merced College students who have paid their Student Health Fee. Contact them for current offerings and to schedule an appointment.



Merced Campus

Student Health Services –

Student Union Building

Phone: (209) 384-6045

Los Banos Campus

Student Health Services –

Student Services Building

Phone: (209) 384-6045

If you are not currently enrolled in a Merced College course, please check with your doctor's office or try searching "TB Testing Near Me" to find a location near you. The flu (influenza) vaccines are often offered at local pharmacies such as Rite Aid, CVS, etc.

CPR Certification

for SONO, RADT, RN, LVN, & CNA students

BLS Provider, Healthcare Provider or Professional Rescuer

The American Heart Association (AHA) name/logo must be printed on your CPR card/certificate. Any CPR card/certificate presented without it will NOT be accepted.

Contact site for pricing and additional information.

Merced College

Contact Sal Lomeli for more info at salvador.lomeli1837@mccd.edu
(209) 381-6540

CPR Instructor, Raj Mehat

Contact Raj Mehat for more info at sukhraj.mehat@mccd.edu

Memorial Hospital Los Banos

520 I St., Los Banos
Contact: (209) 826-0591
extension 50331 or 50244

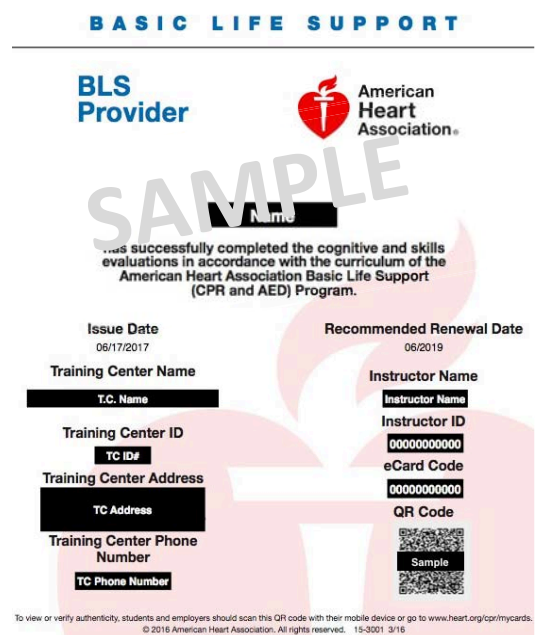
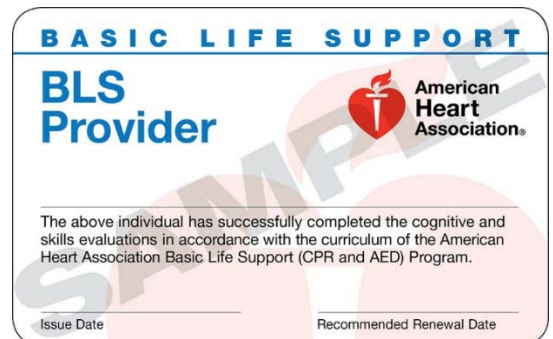
First Lady Permanente, LCC

901 Geer Rd., Turlock
Use Online Code "HOSPITAL" for \$5 off.
(Input at checkout)
Contact: (209) 250-1200
www.firstladypermanente.com

Further training sites can be found on the American Heart Association website: <https://cpr.heart.org>

Select, "Find A Class" in the top-right corner.

Revised: May 8, 2024



Basic Life Support (BLS)

The AHA's BLS course trains participants to promptly recognize several life-threatening emergencies, give high-quality chest compressions, deliver appropriate ventilations and provide early use of an AED. Reflects science and education from the *American Heart Association Guidelines Update for CPR and Emergency Cardiovascular Care (ECC)*.

What does this course teach?

- High-quality CPR for adults, children, and infants
- The AHA Chain of Survival, specifically the BLS components
- Important early use of an AED
- Effective ventilations using a barrier device
- Importance of teams in multirescuer resuscitation and performance as an effective team member during multirescuer CPR
- Relief of foreign-body airway obstruction (choking) for adults and infants