Certified Nurse Aide Program – SUMMER 2016

Program Information:

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 who are 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 cover sheet, Questionnaire, Physical Verification Form & Health Form *(original health form with documentation must be handed in by* ***Friday, June 17****).*
- Mail or bring the application and forms along with a non-refundable $35 administrative fee (credit or 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, the tuition must be paid to the College within five business days of notification.

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.

Students will not be allowed in to the classroom until they have started the payment plan or paid the full course tuition.

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 student that applies to the program must submit a completed 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. Do not submit your health form until it's completed.***

Original form due by: JUNE 17.

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

Health Form Requirements:

Page 1 Personal History – Please provide explanations for any "yes" answers.

Page 2 Immunization History – To be completed by health care provider.

Please attach documentation for the following (incomplete forms will be returned to the student):

Verification of measles, mumps, rubella, and polio vaccinations or titers
Chickenpox – date(s) of vaccination or varicella titer
Tuberculosis testing – chest x-ray if positive results or Quantiferon Gold titer

Provide dates only:

Tetanus shot – must be done within the past 10 years
Flu shot – Spring and Fall applicants only
Hepatitis B series (optional) or signed waiver and risk form

Page 2 Physical Exam – Must be within the last year. All areas must be completed by your health care provider. Heart rate, blood pressure, and hematocrit or hemoglobin must be documented in numbers.

NOTE: This form must be in place by the deadline date (listed on previous page) in order for a student to be eligible for the lab and clinical experience.

Students who successfully complete the C.N.A. program are eligible to receive college credit through the Connecticut Credit Assessment Program administered by Charter Oak State College. Students should request a copy of their program transcript from the Continuing Education Office to be sent to Charter Oak. Credits may be used at Charter Oak State College or transferred to another school by setting up a credit registry with Charter Oak (any transfer credit is at the discretion of the institution).

http://www.charteroak.edu/current/programs/creditregistry.cfm

Please be advised that if you have been convicted of a felony, 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.

COSTS ASSOCIATED WITH THE TUNXIS CNA PROGRAM – SUMMER 2016

Fees Due Directly to Tunxis Community College:

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

$925 tuition* – with Day or Evening Clinical ➡
$975 tuition* – with Saturday Clinical ➡
*includes malpractice insurance and state examination fee

Payment Plan Option:

1st Payment**	2nd Due July 14
$500	$450
$500	$500

*****Includes a $25 installment fee. Contact or stop by the Continuing Education office (Bldg 700) before setting up your payment plan 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

$100 (estimated) textbook
payable to Follett Bookstore at Tunxis

$170 (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 860.223.0889.

For a complete listing of services and locations, please visit:

ctdol.state.ct.us

TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program

WITH DAY CLINICAL
June 2 – August 29, 2016

Mandatory Orientation: Thursday June 2, 10am-1pm in Room 6-127

Lecture Dates – Room 6-127 11 Mondays 6-9:15PM, 1 Tuesday	Lab Dates – Room 202 Tuesday or Thursday or Friday, 7:30AM-1PM		
June 6	June 7 or	June 9 or	June 10
June 13	June 14 or	June 16 or	June 17
June 20 **Quiz 1**	June 21 or	June 23 or	June 24
June 27	June 28 or	June 30 or	July 1
July 5 (Tuesday)	July 5 or	July 7 or	July 8
	Midterm Lab Evaluation		
	Clinical Dates – 7:30AM-2PM		
July 11 **Midterm Exam**	July 12 or	July 14 or	July 15
July 18	July 19 or	July 21 or	July 22
July 25 **Quiz 2**	July 26 or	July 28 or	July 29
August 1 **Quiz 3**	Aug. 2 or	Aug. 4 or	Aug. 5
August 8 **Medical Abbreviations Quiz**	Aug. 9 or	Aug. 11 or	Aug. 12
August 15	Aug. 16 or	Aug. 18 or	Aug. 19
August 22 **Final Examination** **State Written Certification Examination**	Aug. 23 or **Final Clinical Evaluation –** Tunxis 202	Aug. 25 or	Aug. 26

Monday, August 29 **- State Certification Skills Practice Lab/Examination – Tunxis 202**

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory

TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program

WITH EVENING CLINICAL
June 2 – August 29, 2016

Mandatory Orientation: Thursday June 2, 10am-1pm in room 6-127

Lecture Dates – Room 6-127 11 Mondays 6-9:15PM, 1 Tuesday	**Lab Dates – Room 202** Wednesdays, 4-9:30PM
June 6	June 8
June 13	June 15
June 20 **Quiz 1**	June 22
June 27	June 29
July 5 (Tuesday)	July 6 **Midterm Lab Evaluation**
	Clinical Dates – 4-10:30PM
July 11 **Midterm Exam**	July 13
July 18	July 20
July 25 **Quiz 2**	July 27
August 1 **Quiz 3**	Aug. 3
August 8 **Medical Abbreviations Quiz**	Aug. 10
August 15	Aug. 17
August 22 **Final Examination** **State Written Certification Examination**	Aug. 24 – Tunxis 202 **Final Clinical Evaluation**

Monday, August 29 **- State Certification Skills Practice Lab/Examination –** Tunxis 202

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory

TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program

WITH SATURDAY CLINICAL
June 2 – August 29, 2016

Mandatory Orientation: Thursday June 2, 10am-1pm in room 6-127

Lecture Dates – Room 6-127 11 Mondays 6-9:15PM, 1 Tuesday	**Lab Dates – Room 202** Saturdays, 7:30AM-1PM 1 Thursday, 4-9:30PM
June 6	June 11
June 13	June 18
June 20 **Quiz 1**	June 25
June 27	June 30 **(Thursday 4-9:30pm)**
July 5 (Tuesday)	July 9 **Midterm Lab Evaluation**
	Clinical Dates – 7:30AM-2PM
July 11 **Midterm Exam**	July 16
July 18	July 23
July 25 **Quiz 2**	July 30
August 1 **Quiz 3**	Aug. 6
August 8 **Medical Abbreviations Quiz**	Aug. 13
August 15	Aug. 20
August 22 **Final Examination** **State Written Certification Examination**	Aug. 27 – Tunxis 202 **Final Clinical Evaluation**

Monday, August 29 **- State Certification Skills Practice Lab/Examination –** Tunxis 202

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory

BANNER ID ______________________ FEE PAID ON __________________ CC _________ CRN ______________

TUNXIS COMMUNITY COLLEGE
CERTIFIED NURSE AIDE PROGRAM 2014

☐ SPRING ☐ SUMMER ☐ FALL

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

EVE: ☐ Wednesday ☐ Thursday

Please check box if interested in an Accelerated Program ☐

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.

List employment history below.

Tuition Payment Source ☐ Self ☐ Agency (Agency Name, Caseworker and phone # **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 CNA registration form is complete and accurate.

Signed____ Date____________________

TUNXIS COMMUNITY COLLEGE
CERTIFIED NURSE AIDE PROGRAM

Name: ____

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

Tell us about yourself.

Five qualities you possess that would 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: ____________

Name: ____ Date: _______________

Check if you Agree, Disagree, or 'N/A' if it doesn't apply.

1. I have trouble knowing what to study for a test. ☐ Agree ☐ Disagree ☐ N/A

2. I need a friend with whom to discuss important things. ☐ Agree ☐ Disagree ☐ N/A

3. I am swamped by details and facts when I study. ☐ Agree ☐ Disagree ☐ N/A

4. I have recently endured the death of a family member or pet. ☐ Agree ☐ Disagree ☐ N/A

5. There has recently been a change of health for a family member. ☐ Agree ☐ Disagree ☐ N/A

6. I am overburdened with responsibility. ☐ Agree ☐ Disagree ☐ N/A

7. I usually work best against a tight deadline. ☐ Agree ☐ Disagree ☐ N/A

8. I seem never to have enough leisure time. ☐ Agree ☐ Disagree ☐ N/A

9. It is not easy for me to make friends. ☐ Agree ☐ Disagree ☐ N/A

10. I need more time for my family. ☐ Agree ☐ Disagree ☐ N/A

11. I rarely have enough money to meet expenses. ☐ Agree ☐ Disagree ☐ N/A

12. I have recently gained a new family member. ☐ Agree ☐ Disagree ☐ N/A

13. I have had a change in my financial state. ☐ Agree ☐ Disagree ☐ N/A

14. Money is going to be very tight for me this year. ☐ Agree ☐ Disagree ☐ N/A

15. I am experiencing a great deal of family friction. ☐ Agree ☐ Disagree ☐ N/A

16. I have to do jobs I can't cope with. ☐ Agree ☐ Disagree ☐ N/A

17. I am experiencing a change in living conditions. ☐ Agree ☐ Disagree ☐ N/A

18. Most health care personnel are overworked. ☐ Agree ☐ Disagree ☐ N/A

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 an 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? ☐ **Yes** ☐ **No**
(i.e. arthritis, injury, surgeries, etc.)

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.

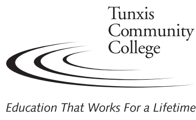
Please list any other conditions that you feel may present a risk for you or that your Instructor should be aware of to protect your well-being and safety.

____

____

____

Student Signature ____ *Date:*_______________________



STUDENT HEALTH FORM

Banner ID: ____________

- [ ] CMAA
- [ ] RMA
- [ ] CNA
- [ ] PHLEBOTOMY

Board of Regents for Higher Education

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

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"*	7. HEART DISEASE			12. HIGH BLOOD PRESSURE		
3. CHICKEN POX			*answers must*	8. HEART MURMUR			13. ALLERGIES		
4. GERMAN MEASLES			*be explained*	9. DIABETES			14. FAINTING SPELLS		
5. WHOOPING COUGH			*below.*	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.1, 1969 — ***Laboratory report must be attached to form.***

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

MUMPS: ______________________ or Titer › Immune? ❑ YES ❑ NO
date/given on or after 1st birthday — ***Laboratory report must be attached to form.***

RUBELLA: ______________________ or Titer › Immune? ❑ YES ❑ NO
date/given on or after 1st birthday — ***Laboratory report must be attached to form.***

POLIO: ______________________ or Titer › Immune? ❑ YES ❑ NO
date(s) of immunization — ***Laboratory report must be attached to form.***

VARICELLA (Chicken Pox): ______________________ or Titer › Immune? ❑ YES ❑ NO
date(s) of immunization — ***Laboratory report must be attached to form.***

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

FLU VACCINE (spring and fall applicants only) ______________________

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

* Date no earlier than March 1 of the year of admission to the program. A student with a positive PPD or previous inoculation with BCG must provide a chest x-ray report with appropriate medical follow-up.

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	HEMATOCRIT OR HEMOGLOBIN		

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

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

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