Certified Nurse Aide Program – Fall 2017

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 must be handed in by October 6).
- 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. 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: Friday, October 6.

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 – SUMMER 2017

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:

<table>
<thead>
<tr>
<th>1st Payment**</th>
<th>2nd Due Oct. 27</th>
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<tbody>
<tr>
<td>$500</td>
<td>$475</td>
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<td>$500</td>
<td>$524</td>
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</table>

**Includes a $25 installment fee.

Contact or stop by the Continuing Education office (Bldg 700) before setting up your 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 860.827.6200.

For a complete listing of services and locations, please visit: ctdol.state.ct.us
**MANDATORY ORIENTATION:** Thursday, September 14  10AM-1PM  room 6-173

<table>
<thead>
<tr>
<th>Lecture Dates – Room 6-173</th>
<th>Lab Dates – Room 202</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mondays 6-9PM</strong></td>
<td><strong>Tuesdays or Fridays 7:30AM-1PM, or Sat. 8AM-1:30PM</strong></td>
</tr>
<tr>
<td>September 18</td>
<td>September 19 or 22 or 23</td>
</tr>
<tr>
<td>September 25</td>
<td>September 26 or 29 or 30</td>
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<tr>
<td>October 2  <strong>Quiz 1</strong></td>
<td>October 3 or 6 or 7</td>
</tr>
<tr>
<td>October 9</td>
<td>October 10 or 13 or 14</td>
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<td>October 16</td>
<td>October 17 or 20 or 21</td>
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<td></td>
<td><strong>Midterm Lab Evaluation</strong></td>
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</tbody>
</table>

**Clinical Dates – 7:30AM-2PM**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 23</td>
<td>Midterm Exam</td>
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<tr>
<td>October 30</td>
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<tr>
<td>November 6</td>
<td><strong>Quiz 2</strong></td>
</tr>
<tr>
<td>November 13</td>
<td><strong>Quiz 3</strong></td>
</tr>
<tr>
<td>November 27</td>
<td><strong>Medical Abbreviations Quiz</strong></td>
</tr>
<tr>
<td>December 4</td>
<td></td>
</tr>
<tr>
<td>December 11</td>
<td><strong>Final Exam/State Written Certification Exam</strong></td>
</tr>
</tbody>
</table>

**Final Exam/State Written Certification Exam**

Monday, December 18: **State Certification Skills Examination**

Passing Grade: 75%  
Clinical: Satisfactory/Unsatisfactory
TUNXIS COMMUNITY COLLEGE
Certified Nurse Aide Program
WITH EVENING CLINICAL
September 14 – December 18, 2017

MANDATORY ORIENTATION: Thursday, September 14 10AM-1PM room 6-173

<table>
<thead>
<tr>
<th>Lecture Dates – Room 6-173</th>
<th>Lab Dates – Room 202</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mondays 6-9PM</td>
<td>Wednesdays 4-9:30PM</td>
</tr>
</tbody>
</table>

- September 18
- September 25
- October 2 **Quiz 1**
- October 9
- October 16
- October 23 **Midterm Exam**
- October 30
- November 6 **Quiz 2**
- November 13 **Quiz 3**
- November 27 **Medical Abbreviations Quiz**
- December 4
- December 11 **Final Exam/State Written Certification Exam**
  - December 13 *8AM-2:30PM*

**Clinical Dates – 4-10:30PM**

- October 25
- November 1
- November 8
- November 15
- November 29
- December 6
- December 13

Monday, December 18: **State Certification Skills Examination**

Passing Grade: 75%

Clinical: Satisfactory/Unsatisfactory
TUNXIS COMMUNITY COLLEGE
CERTIFIED NURSE AIDE PROGRAM 2017

Clinical (check only one):  □ Spring  □ Summer  □ Fall

Clinical (check only one):  DAY: □ Tuesday  □ Friday  □ Saturday
EVE: □ Wednesday

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______________________
Name: _____________________________________________________________________

Do you have transportation? □ Yes □ No

Tell us about yourself.

What is your primary language? ____________________________________
(Note: 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: ___________
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  Please list any medications here:

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

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: ______________________
HEPATITIS B RISK FORM

I understand that due to my possible exposure to blood, body fluids and other potentially 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
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)  
Page 1
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
TUNXSIS COMMUNITY COLLEGE, Attention: Cheryl Conaty, RN
271 Scott Swamp Road • Farmington, Connecticut 06032-3187

APPLICANT: Please print. Complete this side.

APPLICANT

<table>
<thead>
<tr>
<th>Name (last, first, middle)</th>
<th>Social Security #</th>
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<table>
<thead>
<tr>
<th>Permanent Home Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
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<tr>
<th>Sex</th>
<th>Marital Status</th>
<th>Date of Birth (month, day, year)</th>
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IN CASE OF EMERGENCY

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<tr>
<th>Name (last, first, middle)</th>
<th>Relationship</th>
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<table>
<thead>
<tr>
<th>Address (number &amp; street, city or town, state, zip code)</th>
<th>Telephone # (include area code)</th>
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</table>

FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>CANCER</th>
<th>TUBERCULOSIS</th>
<th>DIABETES</th>
<th>ALLERGY OR ASTHMA</th>
<th>EPILEPSY OR CONVULSIONS</th>
<th>STROKE</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th></th>
<th>HEART DISEASE</th>
<th>NERVOUS OR MENTAL ILLNESS</th>
<th>MIGRAINE HEADACHES</th>
<th>HIGH BLOOD PRESSURE</th>
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PERSONAL HISTORY

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</table>

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
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**.

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>1st dose</th>
<th>2nd dose</th>
<th>Immune?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>date given on or after 1st birthday &amp; after Jan. 1, 1969</td>
<td>date given after Jan. 1, 1980</td>
<td>Immune?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Mumps</td>
<td>date given on or after 1st birthday</td>
<td>date given on or after 1st birthday</td>
<td>Immune?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Rubella</td>
<td>date given on or after 1st birthday</td>
<td>date(s) of immunization</td>
<td>Immune?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Polio</td>
<td>date(s) of immunization</td>
<td>date(s) of immunization</td>
<td>Immune?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Flu Vaccine** (spring and fall applicants only)

- **Varicella (Chicken Pox)**: date(s) of immunization
- **Td (Tetanus booster)**: date must have been given within the last 10 years

**Physical Examination**

<table>
<thead>
<tr>
<th>Area</th>
<th>Comments and Recommendations</th>
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</thead>
<tbody>
<tr>
<td>EYES</td>
<td>Vision (R)</td>
</tr>
<tr>
<td>EARS</td>
<td>Drums</td>
</tr>
<tr>
<td>Nasopharynx</td>
<td>Septum</td>
</tr>
<tr>
<td>Teeth</td>
<td>Occlusion</td>
</tr>
<tr>
<td>Neck</td>
<td>Cervical Nodes</td>
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<tr>
<td>Chest</td>
<td>Breasts</td>
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<tr>
<td></td>
<td>Heart (Rate)</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Liver</td>
</tr>
<tr>
<td>Skeletal</td>
<td>Spine</td>
</tr>
<tr>
<td>CNS</td>
<td>Reflexes</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Urinalysis (Lab Reports Required)</td>
</tr>
</tbody>
</table>

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.