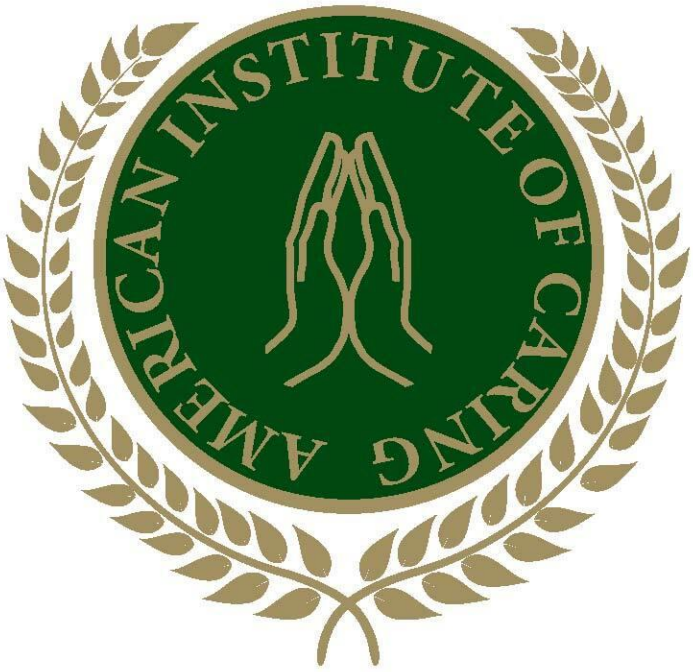

2024
75-Hour Two Week
Nursing Assistant Program
Enrollment Packet

Supply & Entry Requirements Checklist for 75-Hour Basic CNA Course

Class Requirements

All students are required to purchase/aquire the following and bring/wear to 1st day of class.

Attire & Accessories: Students will NOT be permitted to attend class if out of dress code.

- ☐ Student must purchase plain black scrubs (top and bottom, any brand)
- ☐ Student can purchase plain black or white long sleeve to go under scrubs
- ☐ Student must wear all white closed toed shoes (no open heeled shoes, or crocs)
- ☐ Student must wear an analog watch (must have a second hand)
- ☐ Student must bring stethescope
- ☐ A gait belt is included in tuition and provided on first day, must bring to every class
- ☐ A name tage is included in tuition and provided on first day, must bring to every class

Recommended Classroom Supplies: Students can purchase the following and bring to class.

- ☐ 3- Ring Binder
- ☐ Pens, Pencils and highlighters
- ☐ Textbook and workbook (included in tuition and provided on first day, bring to every class)

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Supply & Entry Requirements Checklist for 75-Hour Basic CNA Course

ALL FORMS must be submitted & approved 7 days prior to start of the CNA Program.

In order to attend classes, all students must complete the course requisites prior to enrolling in the Nurse Aid Course in compliance with State Law, Iowa Code Section 135C.33

Form Requirements:

- ☐ **Background Check Form:** (Students who do not pass the background check due to criminal conviction or history of abuse will not be permitted to attend the course.)
- ☐ **Course Enrollment Application:** (Emergency contact, background check info., initial and sign.)
- ☐ **Authorization for Medical Release Form Annual Physical:** (Annual physical completed within the last 12 months. Submit this form to your medical provider to fill out.)
- ☐ **Nursing Assistant Program Record of Vaccination Form & Proof of Vaccination:** (Annual Influenza Vaccination is required of Nurse Aide Students and Faculty who have clinical contact with residents during the months of October 1st through May 31st. Fill out the form and attach a copy of proof of immunization.)
- ☐ **Health and Public Service Department Record of TB Testing Form:** (Completed and Signed by Medical Provider – Physician, Nurse Practitioner, or Licensed Designee, Complete 2-Step TB Skin Test or QuantiFERON Gold Lab Test or Chest X-Ray, must be done within the last 12 months.)
- ☐ **Adult & Child Mandatory Reporter Courses:** (Make a copy of completion certificates and submit with forms.)
- ☐ **Proof of CPR Completion:** (Make copy of completion certificate and submit with forms.)
- ☐ **Course Withdrawal Policy:** (Read and signed.)

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Iowa Division of Criminal Investigation
Criminal History Record Check Request Form

DCI Account number (if applicable)

REQUESTOR INFORMATION PLEASE WRITE CLEARLY

Name (business or individual)

American Institute of Caring

Mailing address (street/PO Box, city, state, zip code)

1801 25th St, West Des Moines, IA 50266

Phone number

(515) 661 - 6730

Fax number

Email address

hr@iowahomecare.com

I would like the results sent to me by: ○ Mail ○ Fax ◉ Email

I am required to have the results notarized: ○ Yes ◉ No ***for specific requirements in another country only.**

SUBJECT OF REQUEST INFORMATION.

Please provide all required demographic information on the form or it will be returned. Multiple names require a separate Request Form and fee.

LAST NAME (required)

FIRST NAME (required)

MIDDLE NAME (recommended)

DATE OF BIRTH (required)

GENDER M, F or Other (required)

SOCIAL SECURITY NUMBER (recommended)

RELEASE AUTHORIZATION INFORMATION: Without a signed release from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a signed release from the subject of the request. This form (DCI-77) is the only approved release authorization form for this purpose.

This response only includes public criminal history data. Under Iowa law, most juvenile records are confidential. Confidential juvenile court records cannot be included in this response. A signed release authorization is not sufficient to obtain this information from the DCI. In order to request the release of confidential juvenile records, if any, an application must be filed pursuant to Iowa Code 232.147(18) through the Clerk of Court. Criminal history data concerning convictions for certain juvenile sex offenses can be found online through the the Iowa Sex Offender Registry (SOR). Even though some information is available online through the SOR, the actual records for juveniles may still be confidential and cannot be provided. In order to request the release of confidential juvenile records, if any, an application must be filed pursuant to Iowa Code section 232.147(18) through the Clerk of Court.

RELEASE AUTHORIZATION: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law. I understand this can include information concerning completed deferred judgments and arrests without dispositions. I understand the signature below certifies the information provided is true and accurate. Furthermore, I understand this is an official statement and record. Any false statement(s) made in this record may result in further action.

RELEASE AUTHORIZATION SIGNATURE

FOR DCI USE ONLY

As of **a search of the information provided revealed:**

○ **NO IOWA CRIMINAL HISTORY RECORD FOUND WITH DCI**

○ **AN IOWA CRIMINAL HISTORY RECORD WAS FOUND. A COPY OF THE RECORD IS INCLUDED - DCI#**

Processed by

SUBMIT THE REQUEST/BILLING FORM(S) AND FEE(S) BY ONE OF THE FOLLOWING METHODS:

ADDRESS: Iowa Division of Criminal Investigation
Support Operations Bureau
Dissemination Unit
215 E 7th St
Des Moines IA 50319

FAX: 515-725-6080

EMAIL: dcirecordchecks@dps.state.ia.us

QUESTIONS: dcirecordchecks@dps.state.ia.us

Course Enrollment Application

First Name: _____ Middle Name: _____ Last Name: _____

Mailing Address (street): _____

Mailing Address Cont. (city, state, zip) _____

Email: _____ Phone Number: _____

Emergency Contact Information:

Emergency Contact Name: _____ Relationship to Student: _____

Emergency Contact Phone: _____ Email: _____

Background Check Information:

Be Advised: Students must pass the background check and if prohibited from participation due to criminal background, the course fees and costs are non-refundable.

Maiden Name or Other Names Used: _____

Date of Birth: _____ Social security number: _____

Gender Assigned at Birth:

- ☐ Male
- ☐ Female

Have you ever been convicted of a felony?

- ☐ Yes
- ☐ No

If Yes Explain:

_____

_____

_____

Have you ever been under investigation for abuse?

- ☐ Yes
- ☐ No

If Yes Explain:

_____

_____

_____

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Course Enrollment Application

Please Read and Initial the Following:

_____I understand that I must have all required forms, immunizations, and CPR/Dependent Abuse completion certifications prior to the start of the course.

_____I understand that I must be in good physical condition with no health limitations. I will provide doctor's approval for participation or verification specifying limitations if pregnancy or limitations exist.

_____I understand that I must pass the background check and if prohibited from participation due to criminal background, the course fees and costs are non-refundable.

_____I understand I must abide by the dress code which includes plain black scrub uniform, plain white or black shoes, and watch with a secondhand or I will not be permitted to attend class.

_____I understand cancellation requests must be received 72-hours prior to the start of the program to receive a refund minus the $150 administration cancellation fee and $20 background check fee.

_____I understand students are expected to have 100% participation and attendance and maintain an average classroom grade of a minimum of 75% in the course.

_____ I also understand that if I do not maintain a 75% grade average during the classroom portion of the course, I will not be permitted to continue to clinicals and will not be able to finish the course.

_____ I understand that students that do not complete 30 hours of classroom, 15 hours of lab, and 30 hours of clinicals will not be eligible for course completion.

I certify that the above information is true and correct. I give permission to American Institute of Caring to run a criminal background check.

Student Signature: _____ Date: _____

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AUTHORIZATION FOR MEDICAL RELEASE OF ANNUAL PHYSICAL EXAM

Complete the Information Below Completely (Please Print)

First Name: _____ Last Name:_____
Middle Initial: _____ Date of Birth: _____

I, _____(student), do hereby authorize my medical provider,

_____, to release my medical examination, to the American Institute of Caring, which is relevant to my educational program.

Student Signature: _____ Date: _____

State of Health
To Be Completed by A Healthcare Provider (Please Print)

Clinic: _____ Provider Name and Title: _____

Street Address: _____ City/State/Zip: _____

Office Telephone: _____ Office Fax: _____

☐I have examined the patient and have determined that this person is in good physical and mental health, has no signs or symptoms of communicable diseases, and is able to function and perform all educational/training duties without any physical limitations in his or her profession or education at full capacity.

☐I have examined the patient and have determined that this person has limitations/restrictions surrounding his or her educational/training duties that include:

_____
_____
_____

_____ _____
Signature of Provider **Date**

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NURSING ASSISTANT PROGRAM RECORD OF INFLUENZA VACCINATION

Annual Influenza Vaccination is required of Nurse Aide Students and Faculty who have clinical contact with residents during the months of October through May.

Complete the information below completely (Please Print)

First Name _____ Last Name _____

Middle Initial _____ Date of Birth _____

Program: ☐ 75- Hour CNA (Basic) ☐150- Hour CNA Course (Advanced)

☐ Due to medical contraindications, religious or philosophical exemptions, I **DECLINE** the influenza vaccine.

☐This record is evidence and/or documentation that I **HAVE RECIEVED** the flu vaccine.

Please provide a copy of your influenza vaccine

OR

Have your medical provider fill out the below information

Influenza Vaccine	
Date and Time Administered	Date / / Time
Site	☐ Right Deltoid ☐ Left Deltoid ☐ Nasal
Manufacture	
Expiration Date	
Lot #	
Administering Provider	Print: Signature:
Clinic Name and Office Number	

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HEALTH AND PUBLIC SERVICE DEPARTMENT RECORD OF TB TESTING

Complete the information below completely (Please Print)

First Name _____ Last Name _____

Middle Initial _____ Date of Birth _____

Program: ☐ 75-Hour CNA Course (Basic) ☐150-Hour CNA Course (Advanced)

☐ 75-Hour CNA Course (Online) ☐ 150-Hour CNA Course (Online)

Risk Factors and Questionnaire		
1. One of more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, excessive unplanned weight loss, excessive fatigue)	☐Yes	☐ No
2. Are you currently pregnant	☐Yes	☐ No
3. Have you had a TB test in the past 12 months	☐Yes	☐ No
4. Have you had a positive TB test in the past?	☐Yes	☐ No
- If yes, did you receive treatment	☐Yes	☐ No
5. Have you received the Bacillus Calmette-Guerin (BCG) vaccine in the past	☐Yes	☐ No

I understand that this test is required as a condition of acceptance into the CNA program and consent to have a tuberculin skin test (PPD) performed.

Name (print): _____ Date: _____

Signature: _____ Date: _____

TURN PAGE OVER

Completed and sign by your Medical Provider (Physician, Nurse Practitioner or Licensed Designee)

A period of more than 7 days but less than 1 year will be needed between TB skin test #1 and #2.

Tuberculin Skin Testing (TST)	#1 TB Skin Test	#2 TB Skin Test
Date and Time Administered	Date / / Time am pm	Date / / Time am pm
Location (circle)	☐ L Forearm ☐R Forearm	☐ L Forearm ☐ R Forearm
Manufacturer		
Expiration Date & Lot Number	Exp._____/ Lot #	Exp._____/ Lot #
Comments/Adverse Reactions		
Signature of Administering Provider		
Results *(read 48-72 hours after admin)*	***First Step Results***	***First Step Results***
Date and Time Read:	Date / / Time am pm	Date / / Time am pm
Number of mm of induration:	____ mm	____ mm
Interpretation of reading: (Circle)	☐ Positive ☐ Negative	☐ Positive ☐ Negative
Signature of Provider Reading Result		

QuantiFERON Gold Blood Test	
Lab Test Obtained (date):	Must Submit a copy of lab results

Chest X-ray (if positive PPD or history of TB)	
Date of Radiology Imaging:	Must submit a copy of chest X-ray results

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State of Iowa Mandatory Reporter

In Iowa, two separate mandatory reporter trainings are required for healthcare workers. Each training is two hours and available in English and Spanish. The two mandatory reporter trainings are Child Abuse & Dependent Adult Abuse. The updated mandatory reporter trainings are now separate, two hours each, and both the child abuse and the dependent adult abuse trainings must be completed. You will turn in BOTH your completion certificates with this form

Mandatory Reporter: Child Abuse

Date Taken: _____

☐ **Certificate Attached**

Mandatory Reporter: Dependent Adult Abuse

Date Taken: _____

☐ **Certificate Attached**

Frequently Asked Questions about Mandatory Reporter Training

The one-hour refresher training is no longer available. For those who have already completed the one-hour refresher trainings, the Board of Educational Examiners can only accept these trainings if you have taken both of the new, separate, two-hour trainings, completed after July 1, 2019, and you did not let the new, separate, two-hour trainings expire, and you uploaded all certificates completed after 2019 as proof. In most cases, it is much easier to complete both two-hour trainings again to make sure you have the correct certificates of completion.

Do I need to complete trainings for both child and dependent adult abuse?

Yes. Do the online application when you renew your license.

Is my mandatory reporter training still valid?

Check the completion date. Training completed before July 1, 2019, is valid for five years, and training completed on or after July 1, 2019, is valid for three years.

Where do I go to complete the training?

AEA Learning System Online
https://training.aealearningonline.org/index_login.php
or
Iowa Department of Health and Human Services
Mandatory Reporters | Health & Human Services

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Proof of CPR Completion

You Must have a Current American Heart Association Basic Life Support (BLS) Certification.

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).

The AHA's BLS Course is designed for healthcare professionals and other personnel who need to know how to perform CPR and other basic cardiovascular life support skills in a wide variety of in-facility and prehospital settings. This course teaches 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 multi-rescuer resuscitation and performance as an effective team member during multi-rescuer CPR, Relief of foreign-body airway obstruction (choking) for adults and infants.

Basic Life Support (BLS) Course Certificate:

- ☐ **American Heart Association Classroom BLS**

  Expiration Date: _____

or

- ☐ **American Heart Association Blended Learning HeartCode BLS**

  Expiration Date: _____

- ☐ Please attach copies of your completion certificate with this form.

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CNA COURSE WITHDRAWAL POLICY

Cancellation requests must be received 72 hours prior to the start of the program and must be completed by filling out the American Institute of Caring Withdrawal Form. If the cancellation request is received 72 hours prior to the start of the program, the program costs will be refunded, with the exception of a $150 administration fee. No refunds will be made after 72 hours prior to the start of the course. No-shows on the first day of the course do not validate a drop or refund of registration fee. Emergency withdrawal during the course may be considered with appropriate documentation.

I understand and agree that there is no refund of tuition if the cancelation request is not received within 72 hours prior to the start of the program and assume full financial responsibility.

_____ _____

Student Signature Date

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