Merced College Nurse Assistant Training Program

Check-Off Form

Name Susie Cormi	chael	M	C Student I.D. #
Language most spoken at home* Eng	lish	Other language(s) spoken (If ap	plicable)* Spanish
Ethnicity/ies* African-Amer		All items listed are required. *	These responses are collected for grant purposes.
Attention: Upon verification of your Nurs You will not be able to registe	se Assistant Program de r in the ALLH-63 course	ocuments, you will be issued a without the voucher.	registration voucher (space permitting).
All documents listed below must be	submitted at the tin	e you apply, no exceptions	. You must provide your own copies.
Please submit the documents in this o	rder:	Dall	US
Apply for College Admission. Comp information is available online: http:	lete appropriate registra s://www.mccd.edu – Se	tion procedures and obtain a St ect the "Enroll" feature, then fo	udent I.D. card. Further Registration Ilow the steps provided.
High School Students — You must be at le need to submit a k-12 form. Please talk v			course. If your application is accepted, you may
Nurse Assistant Check-Off Form (Th	is Form)	MUUM	3
Three (3) copies of the Nurse Assist www.cdph.ca.gov. Follow instruction website.	ant Initial Application - ns provided in the Nurse	CDPH 283 B form (see Table of Assistant Orientation Video. Al	Contents) - The form is located online: ways use the most current form on the
All students are required to be fingerprin on a separate date, should your applicati	ted and possess a <u>current C</u> ion be accepted. Further inf	alifornia ID or Driver's License. Fing ormation will be provided at the tim	perprinting may take place on the day you apply or e you apply.
Health Evaluation (See Table of Con the Spring class which starts in Janua	tents). This needs to be ary, your health evaluati	completed <u>within 6 months of completed</u> between	lass start date – Example: If you are taking n July and the application date.
COPY of negative TB skin test or Qu completed within 6 months of class would be completed between Febru	start date – Example: If	ou are taking the Fall class which	chest x-ray is needed. This needs to be ch starts in August, your health evaluation
COPY of CPR card for the BLS Provide are in the program. The American H	ler, Healthcare Provider leart Association (AHA)	or Professional Rescuer - certification of the printed on the prin	ication must not expire the semester you your CPR card/certificate.
Flu (Influenza) Vaccine - The flu vaccine becomes available, usually around S		required at time of application;	Summer - not required; Fall - required once it
COVID-19 Vaccine/Booster - Must h become due for them. Follow the cu additional doses. Weekly testing mark	rrent guidelines provide	d by the Centers for Disease Co	ent doses will need to be submitted as you natrol and Prevention (CDC) for obtaining
Having read all of the Merced Coll understand and accept the respon			
2000	7		2/2/22/1

CDPH 283 B (01/22)

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

Page 1 of 3

CERTIFIED NURSE ASSISTANT (CNA) INITIAL APPLICATION

(See instructions on the reverse)

SECTION I (BEOLUBED)					
SECTION I (REQUIRED)					
TYPE OF REQUEST Check here if you are enrolling in a CNA train Check here if you are requesting RECONSID (complete sections I, II, III and V)					
SECTION II (REQUIRED)			antiantinina Pagagani p	ALCONOMIC TO THE PARTY OF THE P	
Last Name	First Na	ame		MI	Sex
Carmichael	Susie		TA		Male Female
Public Address (Required) – Subject to Public Reco Request release *	ords Act	City	AD	State	Zip Code
1234 Any Blvd., Apt. 1A	-	Merced		CA	95341
Confidential Address (Required)- (For CDPH Use of blank all departmental mail will be sent to the address		City		State	Zip Code
	A	(0 4		A
Date of Birth Social Security Number (SSN) or Individual Driver's License /State ID Number Taxpayer Identification Number (ITIN) Number: A1234567 04/09/88 0 0 0 0 0 0 0 0 0 **If you use an invalid SSN, your application process Market State: CA (mm/dd/yy) may be delayed					
Phone Number *** 209-000-0000 Email Address***					
■ By checking this box, you agree to receive tex from the California Department of Public Health (reminders and notifications regarding your applic certification. You may receive up to 5 messages Message and data rates may apply. By checking agree to the Terms and Conditions and Privacy PReply "STOP" to opt-out, and "HELP" for help.	CDPH) fo ation and per month this box,	r /or 1.	susiecarmicha	ael@anyema	il.com

This form is available on our website at: www.cdph.ca.gov

SECTION III (R					
1) Have you bee	en CONVICTED, at any	y time, of any cr	me, other than a	a minor traffic	violation? (You
need not disc	need not disclose any marijuana-related offenses specified in the marijuana reform legislation and				
	Health and Safety Co	de, Sections 11	361.5 and 1136	1.7).	
O Yes	O Yes O No				
If yes, list con	viction:	Date			
Court of conv	th-related licensing, ce			v taken adve	se action
2) Has any healt	nulled, cancelled, susp	ended etc.) and	inst vou?	y taken adver	dollon
O Yes	O No	criaca, cio.) ago	mar you.		
	se/Certificate:				
	ficate Number:				
Type of Action	V 	_			
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SECTION IV (IF APPLICABLE)				
Name of school of	or facility where you red	ceived/will recei	e the CNA train	ing Tele	phone Number
Merced College - Los	ERES 2 1200 1700	Day number 1		209-38 State	A STATE OF THE STA
22240 Highway 152	(Number Street or P.O		City os Banos	CA	Zip Code 95635
	g Program ID Number		Beginning Date		End Date of Training
(Required) CNA:		IOI OILA	Dogiiiiiig Daid	3 or Training	Life Date of Training
(Modaliou) of the			(mm/dd/)	(VV)	(mm/dd/yy)
SECTION V (RE	EQUIRED)				
I certify under pen	alty and perjury under th	ne applicable stat	e and federal law	s that the infor	mation contained in
	d supporting documents				
	nts may result in denial o				· · · · · · · · · · · · · · · · · · ·
	hall have the same legal				a signature or use or a
paper-based recor	d keeping system to the	fullest extent per	mitted by applica	ble law.	
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Printed Name	Title	late.			
Signature	Date				

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SECTION II (REQUIRED)					
Last Name	First Na	ame		MI	Sex
Carmichael	Susie	AI	TO		Male Female
Public Address (Required) – Subject to Public Reco Request release *	ords Act	City		State	Zip Code
1234 Any Blvd., Apt. 1A		Merced		CA	95341
Confidential Address (Required)- (For CDPH Use only. If left City blank all departmental mail will be sent to the address above)				State	Zip Code
	Α.				
Date of Birth Social Security Number (SSN) of	a k la distint	NAME OF THE OWNER, WHEN THE PARTY OF THE OWNER, WHEN THE OWNER	I Divoro	Hisanaa	/State ID Number
Date of Birth Social Security Number (SSN) C	JI III GIVIGU	iai	Dilvers	License	State ID Number
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04/09/88 0 0 0 0 0 0 0 0	0 0		04-4	CA	
<pre>**If you use an invalid SSN, your (mm/dd/yy) may be delayed</pre>	applicatio	n proces	State:	CA	
Phone Number *** Email Address***					
■ By checking this box, you agree to receive tex from the California Department of Public Health (reminders and notifications regarding your application. You may receive up to 5 messages processed and data rates may apply. By checking agree to the Terms and Conditions and Privacy Processed Processed Privacy Privacy Processed Privacy Privac	susiecarmicha	ael@anyema	ail.com		

This form is available on our website at: www.cdph.ca.gov

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). O Yes O 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? O Yes O No Type of License/Certificate: License/Certificate Number: Type of Action: SECTION IV (IF APPLICABLE) Name of school or facility where you received/will receive the CNA training Telephone Number 2023-384-6000 Mailing Address (Number Street or P.O Box number City State Zip Code 95535 California Training Program ID Number for CNA (Required) CNA: 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. Diagnature of Applicant SECTION V: 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. Printed Name Title Signature Date	SECTION III (REQUIRED)				
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	(only applies to students that ha	ve recently completed a	CNA Training Program	n in CA.	
	-				
Signature Date	Printed Name	Title			
Signature Date	Cianatura	Data			
	Signature	Dale			

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

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 train the Check here if you are requesting RECONSID (complete sections I, II, III and V)	ning progr DERATION	am (com N for a pr	plete secti eviously re	ons I, II, evoked/d	III, IV, and V) enied certificate
SECTION II (REQUIRED)					
Last Name	First N	ame		MI	Sex
Carmichael	Susie		IC		Male Female
Public Address (Required) – Subject to Public Red Request release *	cords Act	City	AN	State	Zip Code
1234 Any Blvd., Apt. 1A		Merced		CA	95341
Confidential Address (Required)- (For CDPH Use		City		State	Zip Code
blank all departmental mail will be sent to the addre	ess above)				
	A				
Date of Birth Social Security Number (SSN)	or Individ	ual	Driver's	License	/State ID Number
Taxpayer Identification Number (ITIN)			Numbe	er: A123	4567
04/09/88 0 0 0 0 0 0 0	0 0				
**If you use an invalid SSN, you may be delayed	r applicatio	on proces	State:	CA	
Phone Number *** 209-000-0000 Email Address***					
■ By checking this box, you agree to receive te from the California Department of Public Health reminders and notifications regarding your applicentification. You may receive up to 5 messages Message and data rates may apply. By checking agree to the Terms and Conditions and Privacy Reply "STOP" to opt-out, and "HELP" for help.	(CDPH) for cation and per mont gethis box,	or I/or h.	susiecarmicha	ael@anyema	ail.com

SECTION III (REQUIRED)				
Have you been CONVICTI need not disclose any man codified at the Health and	ijuana-related offenses	specified in the ma	arijuana reform	iolation? (You legislation and
O Yes O No	•			
If yes, list conviction:	NAME OF A PERSON			
Court of conviction:		ate:		
2) Has any health-related lice	nsing, certification or d	isciplinary authority	/ taken advers	e action
(revoked, annulled, cancel	led, suspended, etc.) a	gainst you?		
O Yes O No				
Type of License/Certificate		-		
License/Certificate Number		-		
Type of Action:				•
CECTION IV /IE ADDI IOA	DI E\			
SECTION IV (IF APPLICA		I U ONA train	Talani	anna Niverbau
Name of school or facility whe Merced College - Los Banos			209-384-	
Mailing Address (Number Stre	et or P.O Box number	City Los Banos	State CA	Zip Code 95635
22240 Highway 152 California Training Program ID	Number for CNA	Beginning Date	1000 %	nd Date of Training
(Required) CNA:	Number for CNA	beginning Date	or Training L	and Date of Training
(Required) OIVA:		(mm/dd/y	(V)	(mm/dd/yy)
SECTION V (REQUIRED)				
I certify under penalty and perju	ry under the applicable s	ate and federal laws	that the inform	nation contained in
this application and supporting of				
incorrect statements may result				
electronic means shall have the s				
				signature or use or a
paper-based record keeping syst	em to the fullest extent p	permitted by applica	ble law.	
Ousie Carmichael	MA A	CCTTC	1 4 2/3	31/2024
Signature of Applicant			Date	
SECTION VI: TO BE COMPL	ETED BY THE REGIS	TERED NURSE R	ESPONSIBLE	FOR THE
GENERAL SUPERVISION OF				
			e FOR V	ENDOR USE ONLY
I certify that this individual has sassistant training requirements a	and the same of th	ACCOUNT AND ADDRESS OF THE PARTY OF THE PART	Committee Commit	ENDOR OSE ONLY
(only applies to students that ha				
(only applies to students that ha	ve recently completed a	City Iraning Frogra		
Printed Name	Title		1	
	Data			
Signature	Date			



Merced College Allied Health Physical Health Evaluation

	Leve Control of the C
Susie Carmichael	Date of Birth 4 9 1988
Address, City, State, Zip	3
1234 Any Blvd., Apt. 1A	
Email Address	Phone
Susiecarmichael@anyemail.com	209-550-0000
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, medical problems that would affect the student's ability to partic The CNA, LVN, RN, RT and SONO Programs require the student the heavy lifting, and twist frequently in providing care to patients student must be able to make rapid, sound decisions related to	ipate fully in an Allied Health Program. To be able to stand, bend, perform during procedures. Additionally, the
Vital Signs: Temp. 97.8 Pulse 86 Resp 1	7 BP 120/15
Vision: R 20/20 L 20/20 Hearing:	R WNL L WNL
Heart: Murmur Lungs: C	clear
Back Injuries/Deformities:NDNe	
ABD: normal Comments: Healthy, can perform	all duties
in the CNA Program	
Annica	dian
A A V V AA V S	
By signing below, I CONFIRM this patient's History AND I them to fully participate in the Allied Ho	ealth Program.
2/30/24 Doogie Howser, M.D.	Merced Physicals & Urgent Matters 12345 No St. Merced, CA 209-000-0000
Date Health Care Professional	Facility Stamp OR Attach Provider Business Card

Merced TB/X-Ray Center 54321 Any St.

Merced, CA 209-000-0000

TB TEST RESULTS

PATIÊNT:	Susie	Carmichael	/April.9	, 1988
PATIENT:	Susie	al MI Charl	1111111	, , , ,

EMPLOYER: Student

LOT#: TBXXXX

EXPIRATION DATE: 6/31/2024

DATE TEST COMPLETED: 2/29/2024, 2 30 pm

FOREARM: LEFT

RIGHT

ADMINISTERED BY: Deogie Houser, MD.

RESULTS: <u>negative</u>

DATE READ: 2/31/2024, 3 5mm

READ BY: Oogie Horsen, MD.

Application

BASIC LIFE SUPPORT

BLS Provider



Susie Carmichael

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

Issue Date 2/1/2024 Renew By 2/2026

eCard Code

To view or verify authenticity, students and employers should scan this OR code with their mobile device or go to www.heart.org/cpr/mycards.



Training Center Name

CPR Training LLC

Training Center ID

GAXXXXX

TC City, State Turlock, CA

TC Phone

(209) 000-0000

Training Sile Name

Instructor Name

CPR Superhero

Instructor ID 780CPR

© 2023 American Heart Association 20-3001 R3/23

Directions

- 1. Cut along dotted lines
- 2. Fold both halves together
- 3. Use adhesive to combine halves

mpus

Nurse Assistant Application

A Flu Vaccine, L.L.C. # 0000 Patient Prescription 01/01/2024 - 02/31/2024

Date: 02/03/2024 Time: 8:30AM

PHARMACY NAME: ADDRESS: CITY, ST, ZIP:

A Flu Vaccine, LLC 987456 Any Rd.

Merced, CA

PATIENT NAME: ADDRESS: CITY, ST, ZIP:

Carmichael, Susie 1234 Any Blvd., Apt. 1A Merced, CA

TELEPHONE: BIRTHDATE:

(209) 000-0000 04/09/1988

GENDER

STORE RX NUMBER NO# Store-x RX00000

RFL NDC -NUMBER 000 FLUxxxxxxxx

DRUG DESCRIPTION

FLUCELVAX QUAD 2023-2024 SYR

PRESCRIBER NAME Howser, Doogie, MD

DATE FILLED 02/30/2024

PATIENT OUANT DISP PD AMT 0.50 \$50.00

Nurse Assistant pplication

COVID-19 Vaccination Record Card Please keep this record card, which includes medical information about the vaccines you have received. Por favor, guarde esta tarjeta de registro, que incluye información

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

Camichael Susie

Last Name First Name MI

TIGHT Patient number (medical record or IIS record number)

Product Name/Manufacturer Healthcare Professional or **Vaccine** Date Clinic Site Lot Number 10,31,23 Prizer-Bivalent A Pharmacy, Inc 1" Dose dd COVID-19 уу 2rd Dose mm dd COVID-19 уу Other dd уу Other mm dd уу

Nurse Assistant Application