Merced College

Nurse Assistant Training Program

Check-Off Form

Name Susie Carmichael MC Student I.D. # 0000001

Language most spoken at home* English Other language(s) spoken (If applicable)* Spanish

Ethnicity/ies* African-American *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.

Susie Carmichael
Signature

2/31/2024
Date

State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:

California Department of Public Health (CPDH)
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** 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	First Name	MI	Sex
Carmichael	Susie		○ Male ◉ Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code
1234 Any Blvd., Apt. 1A	Merced	CA	95341
Confidential Address (Required)- (For CDPH Use only. If left blank all departmental mail will be sent to the address above)	*City*	*State*	*Zip Code*

Date of Birth	*Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)*	Driver's License /State ID Number
04/09/88	0 0 0 - 0 0 - 0 0 0 0	*Number:* A1234567
(mm/dd/yy)	***If you use an invalid SSN, your application process may be delayed*	*State:* CA

Phone Number *** 209-000-0000

☑ 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*** susiecarmichael@anyemail.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: _____

SECTION IV (IF APPLICABLE)

Name of school or facility where you received/will receive the CNA training			Telephone Number
Merced College			209-384-6000
Mailing Address (Number Street or P.O Box number	**City**	**State**	**Zip Code**
3600 M St.	Merced	CA	95348
California Training Program ID Number for CNA (Required) CNA: _____	**Beginning Date of Training** _____ *(mm/dd/yy)*		**End Date of Training** _____ *(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.

Susie Carmichael — Signature of Applicant

2/31/2024 — 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.

Printed Name	Title
Signature	Date

FOR VENDOR USE ONLY

State of California- Health and Human Services Agency

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Susie Casmichael — Signature of Applicant

2/31/2024 — Date

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FOR VENDOR USE ONLY

_____ Printed Name

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_____ Signature

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Susie Carmichael — Signature of Applicant

2/31/2024 — Date

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Printed Name	Title	**FOR VENDOR USE ONLY**
Signature	Date	

Merced College
Allied Health
Physical Health Evaluation

Name	Date of Birth
Susie Carmichael	4/9/1988
Address, City, State, Zip	
1234 Any Blvd., Apt. 1A	
Email Address	**Phone**
susiecarmichael@anyemail.com	209-000-0000

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/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. 97.8 Pulse 86 Resp 17 BP 120/75

Vision: R 20/20 L 20/20 Hearing: R WNL L WNL

Heart: murmur Lungs: clear

Back Injuries/Deformities: none

ABD: normal

Comments: Healthy, can perform all duties in the CNA Program

By signing below, I CONFIRM this patient's History AND Physical Condition adequate for them to fully participate in the Allied Health Program.

Date	Health Care Professional	Facility Stamp OR Attach Provider Business Card
2/30/24	Doogie Howser, M.D.	Merced Physicals & Urgent Matters 12345 No St. Merced, CA 209-000-0000

Merced TB/X-Ray Center

54321 Any St.

Merced, CA

209-000-0000

TB TEST RESULTS

PATIENT: Susie Carmichael / April 9, 1988

EMPLOYER: Student

LOT#: TBxxxx

EXPIRATION DATE: 6/31/2024

DATE TEST COMPLETED: 4/29/2024, 2 30 pm

FOREARM: (LEFT) RIGHT

ADMINISTERED BY: Doogie Howser, MD.

RESULTS: negative

DATE READ: 4/31/2024, 3 15 pm

READ BY: Doogie Howser, MD.

BASIC LIFE SUPPORT

BLS Provider

American Heart Association.

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	Renew By	eCard Code
2/1/2024	2/2026	xxxxxxxxxxxx

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

Training Center Name	CPR Training LLC
Training Center ID	CAxxxxx
TC City, State	Turlock, CA
TC Phone	(209) 000-0000
Training Site Name	
Instructor Name	CPR Superhero
Instructor ID	780CPR

Directions

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

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

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

PHARMACY NAME: A Flu Vaccine, LLC
ADDRESS: 987456 Any Rd.
CITY, ST, ZIP: Merced, CA

PATIENT NAME: Carmichael, Susie
ADDRESS: 1234 Any Blvd., Apt. 1A
CITY, ST, ZIP: Merced, CA

TELEPHONE: (209) 000-0000
BIRTHDATE: 04/09/1988
GENDER F

STORE NO #	RX NUMBER	RFL	NDC NUMBER	DRUG DESCRIPTION	PRESCRIBER NAME	DATE FILLED	QUANT DISP	PATIENT PD AMT
Store-x	RX00000	000	FLUxxxxxxxx	**FLUCELVAX QUAD** 2023-2024 SYR	Howser, Doogie, MD	02/30/2024	0.50	$50.00

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 médica sobre las vacunas que ha recibido.

Carmichael — Last Name
Susie — First Name
MI

4/9/1988 — Date of birth
XXXXXX — Patient number *(medical record or IIS record number)*

Vaccine	Product Name/Manufacturer / Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19	Pfizer-Bivalent / GJXXXX	10/31/23 (mm/dd/yy)	A Pharmacy, Inc.
2nd Dose COVID-19		___/___/___ (mm/dd/yy)	
Other		___/___/___ (mm/dd/yy)	
Other		___/___/___ (mm/dd/yy)	