Merced College

Nurse Assistant Training Program

Check-Off Form

Name _____ MC Student I.D. # _____

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

Ethnicity/ies* _____ *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.

_____ _____

Signature Date

Revised: September 6, 2023

To complete this form, please visit www.cdph.ca.gov and search for "cdph283b"

EXAMPLE for Merced Campus

State of California- Health and Human Services Agency

Must be typed.

Print 3 copies of this form!
(Pages 1 & 2 ONLY, page 3 is an instruction sheet. We do not need you to print/submit that page.)

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

(X) 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
Sample Person (Name entered must match name on ID/DL EXACTLY.)	Merced	B.	(X) Male ( ) Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code
1234 Merced St.	Any Town	CA	95348
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
02/29/00 *(mm/dd/yy)*	1 2 3 - 4 5 - 6 7 8 9 **If you use an invalid SSN, your application process may be delayed*	*Number:* A1234567 *State:* CA

Phone Number *** (209)999-9999

Email Address*** mercedsampleperson@yahoo.com

[X] 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.

To complete this form, please visit www.cdph.ca.gov and search for "cdph283b"

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: _____

Check one box for each question.

IF yes, fill in the blanks.

SECTION IV (IF APPLICABLE)

Address must be filled in EXACTLY as shown below.

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 Street	Merced	CA	95348
California Training Program ID Number for **CNA** (Required) CNA: LEAVE BLANK	Beginning Date of Training LEAVE BLANK (mm/dd/yy)		End Date of Training LEAVE BLANK (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.

LEAVE BLANK
Signature of Applicant

LEAVE BLANK
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.

LEAVE BLANK
Printed Name

LEAVE BLANK
Title

LEAVE BLANK
Signature

LEAVE BLANK
Date

FOR VENDOR USE ONLY

It is YOUR responsibility to enter your information correctly on this form.

You should double and triple-check all information before submitting.

To complete this form, please visit www.cdph.ca.gov and search for "cdph283b"

EXAMPLE for Los Banos Campus

State of California- Health and Human Services Agency

Must be typed.

Print 3 copies of this form!

(Pages 1 & 2 ONLY, page 3 is an instruction sheet. We do not need you to print/submit that page.)

MAIL OR FAX APPLICATION TO:

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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)

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TYPE OF REQUEST

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( ) 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
Sample Person (Name entered must match name on ID/DL EXACTLY.)	Los Banos	B.	(X) Male ( ) Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code
1234 Los Banos St.	Any Town	CA	93635
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
02/29/00 *(mm/dd/yy)*	9 8 7 - 6 5 - 4 3 2 1 **If you use an invalid SSN, your application process may be delayed*	*Number:* A7654321 *State:* CA

Phone Number *** (209) 777-7777

Email Address*** losbanossampleperson@yahoo.com

[X] 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.

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   - ◉ Yes ○ No
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   - Court of conviction: _____ Date: _____
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   - ○ Yes ○ No
   - Type of License/Certificate: _____
   - License/Certificate Number: _____
   - Type of Action: _____

Check one box for each question.

IF yes, fill in the blanks.

SECTION IV (IF APPLICABLE)

Address must be filled in EXACTLY as shown below.

Name of school or facility where you received/will receive the CNA training			Telephone Number
Merced College - Los Banos Campus			(209)384-6000
Mailing Address (Number Street or P.O Box number)	City	State	Zip Code
22240 Highway 152	Los Banos	CA	93635
California Training Program ID Number for **CNA** (Required) CNA: LEAVE BLANK	Beginning Date of Training LEAVE BLANK (mm/dd/yy)		End Date of Training LEAVE BLANK (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.

LEAVE BLANK — Signature of Applicant

LEAVE BLANK — 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.

		FOR VENDOR USE ONLY
LEAVE BLANK — Printed Name	LEAVE BLANK — Title	
LEAVE BLANK — Signature	LEAVE BLANK — Date	

It is YOUR responsibility to enter your information correctly on this form.

You should double and triple-check all information before submitting.

Merced College
Allied Health
Physical Health Evaluation

Name	Date of Birth
Address, City, State, Zip	
Email Address	**Phone**

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. _____ Pulse _____ Resp _____ BP _____

Vision: **R** _____ **L** _____ Hearing: **R** _____ **L**_____

Heart:_____Lungs:_____

Back Injuries/Deformities:_____

ABD:_____

Comments:_____

_____

_____

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**

TB Testing & Flu (Influenza) Vaccine

TB:

Students must have a TB skin test or QuantiFERON-TB (QFT) blood test (**within six months of the start of class**) or negative chest x-ray. These must be completed annually while in an Allied Health program.

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

Registered Merced College Students -

Student Health Services provides free TB testing & flu vaccinations to **current** Merced College students who have paid their Student Health Fee. Contact them for current offerings and to schedule an appointment.

Merced Campus

Student Health Services –
Student Union Building
Phone: (209) 384-6045

Los Banos Campus

Student Health Services –
Student Services Building
Phone: (209) 384-6045

If you are not currently enrolled in a Merced College course, please check with your doctor's office or try searching "TB Testing Near Me" to find a location near you. The flu (influenza) vaccines are often offered at local pharmacies such as Rite Aid, CVS, etc.

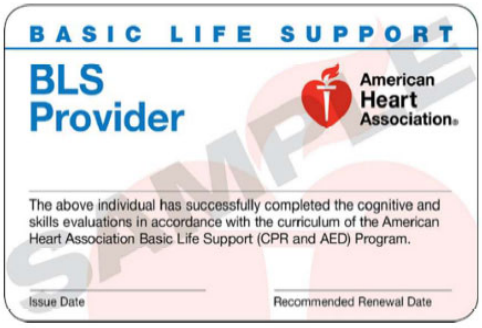
CPR Certification

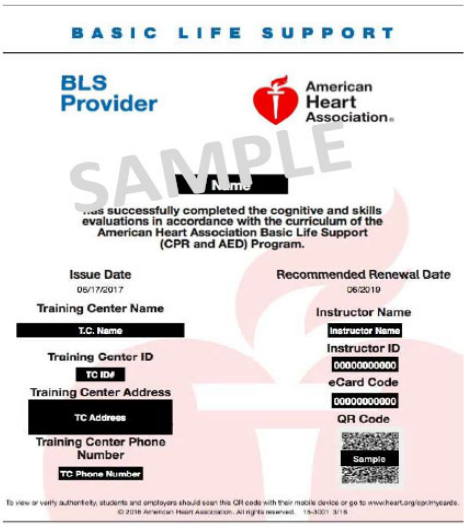
for SONO, RADT, RN, LVN, & CNA students

BLS Provider, Healthcare Provider or Professional Rescuer

The American Heart Association (AHA) name/logo must be printed on your CPR card/certificate. Any CPR card/certificate presented without it will NOT be accepted.

Prices and locations subject to change at any time.





Merced College

Cost: $6

Contact Sal Lomeli for more info at salvador.lomeli1837@mccd.edu

CPR Instructor, Raj Mehat

Cost: $30

Contact Raj Mehat for more info at sukhraj.mehat@mccd.edu

Memorial Hospital Los Banos

520 I St., Los Banos

Cost: $30

Contact: 826-0591 ext. 50331 or 50244

First Lady Permanente, LCC

901 Geer Rd., Turlock

Cost: $65, plus $20 for required book

Use Online Code "HOSPITAL" for $5 off. (Input at checkout)

Contact: 250-1200

www.firstladypermanente.com

Further training sites can be found on the American Heart Association website: https://cpr.heart.org

Select, "Find A Class" in the top-right corner.

The BLS for Healthcare Providers CPR/AED 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 (Automated External Defibrillator). In the Instructor-led course, student participate in simulated clinical scenarios and learning stations. Students work with an AHA BLS certified Instructor to complete BLS skills practice and skills testing. Students also complete a written exam. This provider course requires approximately 4 hours to complete, including skills practice and skills testing.