

**STAFF VERIFICATION:** Desired Class Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

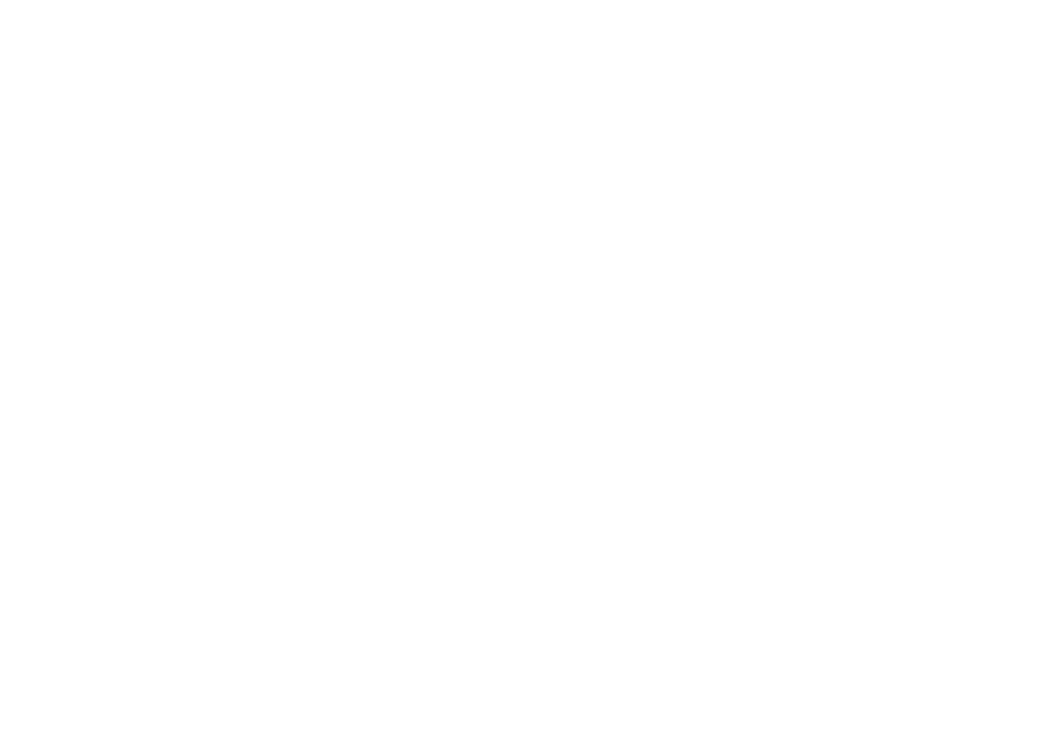
City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Texas Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Students entering the Certified Nurse Aide (CNA) program must meet the following minimum requirements:**

o **Current BLS Certification – Must be valid through the program**

* Required Immunizations document signed and dated by your Healthcare Provider and accompanying shot records **MUST** include:

o ***Hepatitis B (3 shots)***

* ***Tdap (within the last 10 years)***
* ***MMR (2 shots)***
* ***Varicella (2 shots)/TITER***
* ***TB Skin Test Negative (within 1 year)***
* ***Drug screen to be completed after registration fee paid***
* Student Acknowledgement of Hepatitis B form

o Current Healthcare Physical document signed and dated by your Healthcare Provider (no older than 3 months)

* Copy of Social Security Card (**MUST match Photo ID**)
* Copy of Driver’s License or Government Issued Photo ID (**MUST match Social Security Card**) ***[Expired ID will not be accepted]***
* Signed and dated Notice to Students Form

o Current Criminal History/Background Check (Instructions attached)

o Employability Status Check Search (Instructions attached)

o State Exam application fee of $95 will be expected upon successful completion of program

**SUPPLIES AND EQUIPMENT:** Royal blue scrubs, patch on shoulder of scrubs (to be provided), white tennis like shoes, watch with second-hand for clinical, stethoscope, blood pressure cuff, student ID to be worn at all times.

***For more information:*** Contact Steven Payne at 832-472-2390,

# Physical Exam & Immunization Requirements

**Student’s Name**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Last | M/I | First |  |  | Sex | DOB: (DD/MM/YYYY)    / / |
| Weight | Height |  | Pulse | Temp | Blood Pressure  S \_\_\_\_\_\_\_\_\_ D \_\_\_\_\_\_\_\_\_ | |

**List any current illnesses or injuries:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any permanent medical conditions or physical limitations:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:** *(Check if applicable)*

Asthma Heart Disease Tuberculosis Measles

Diabetes Seizures Emphysema Hypoglycemic

Hepatitis Rheumatism Small Pox Tuberculosis

Diphtheria Influenza Pneumonia Infantile Paralysis

Osteoarthritis Mumps Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Please specify)

**(If checked above please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tests:**

**(Please attach proof of results. Must be no more than 1 year old to the date of the class. If results are positive, a chest x-ray is required)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TB Skin Test**  Pos Neg | Date read | Initials |  | **TB Chest X-ray**  Pos Neg | |  | Date read | Initials |
| (\*Attach proof of finding)  **Immunizations** (Give most recent date) | | |  | |  |  | | |
| Hepatitis B (3 shots)  1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Tdap (w/in last 10 yrs) | | MMR (2 shots) | |  | Varicella (2 shots)/Titer | | |

I certify that I have examined this individual and he/she is suitable physically and emotionally for the BAP Life Support CNA Academy to which they are applying for:

Yes No (If no, please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.D.

Date: Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

# NOTICE TO STUDENTS

|  |  |
| --- | --- |
| **Please Initial** | **PLEASE READ AND INITIAL BELOW** |
|  | Your photo ID MUST be current and correct at the time your application is submitted for your NACES exam. |
|  | The name on your Social Security card MUST match the name on your ID. If there is not an exact match, you will NOT be able to take your State exam. |
|  | Student phone numbers MUST be up to date & active. |
|  | Exam and Clinical dates are subject to change without notice. |
|  | State exam dates and times are determined by DADS. You will be notified by NACES once they have confirmed your test date & site. Neither your Instructor nor BAP Life Support has any control over when and where you are assigned. All contact will need to be made to NACES directly. |

**STATE BOARD EXAM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and will comply with the above BAP Life Support CNA Academy and NACES policies.

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Criminal History and Employability Checks Certified Nursing Assistant

## Employability Checks

Applicants found to be listed on the Employee Misconduct Registry or who are listed on the Nursing

Assistant Registry in “revoked” status or who have a criminal history that would bar employment in a Texas Department of Aging and Disability Services (DADS) licensed facility or agency are prohibited from enrolling in a nurse aide training program.

It is understood that I will provide BAP Life Support CNA Academy an EMR check.

***Please initial****.\_\_\_\_\_\_\_\_\_*

Please go to [**https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp**](https://emr.dads.state.tx.us/DadsEMRWeb/emrRegistrySearch.jsp) to request this information. This must be printed out & turned in with all other required documentation.

## Release Agreement

While caring for patients during my clinical rotations, I hereby release and discharge BAP Life Support CNA Academy and all its employees from all liability for all injury, exposure or damage arising from health risks of caring for patients during my clinical rotation or during scheduled class or skills lab. I understand that I may be exposed to communicable diseases *(including blood-borne pathogens)* or personal injury. I am aware of the health risks of caring for such patients.

***Please initial***.\_\_\_\_\_\_\_\_\_\_

I am also aware that the BAP Life Support CNA Academy, which oversees the Certified Nursing Assistant (CNA) Program, requires that I have the required immunizations before my clinical rotations. I understand that I will not be allowed to enter the clinical facility for clinical purposes if I do not have the required immunizations.

***Please initial****.\_\_\_\_\_\_\_\_\_\_*

## Background Check

A background check from the Texas Department of Public Safety is required to be presented by the student for BAP Life Support CNA Academy Please go to the Texas Department of Public Safety website at **https://records.txdps.state.tx.us** to obtain instructions on how to request a criminal history check. The approximate cost for getting a background check is $3.57 for each last name of applicant. This must be turned in with checklist information required for your desired program. **Background checks older than 2 months to the class date you are applying for will not be accepted.**

## Applicant’s Statement

I certify that I have read the above statements and that initialing my name means that I agree with the above statements. If accepted into the BAP Life Support CNA Academy Program, I agree to abide by the rules set forth by the school and the program.

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STUDENT ACKNOWLEDGEMENT OF HEPATITIS B VACCINE**

Department of State Health Services

Disease Prevention & Intervention Section

Immunization Branch

**POLICY STATEMENT** 1.0 Completion of Hepatitis B vaccine series prior to direct patient care

The Texas Department of State Health Services (DSHS) rule §97.64,

“Required Vaccinations for Students Enrolled in Health-Related and Veterinary Courses in

Institutions of Higher Education” [25TAC§97.64, April 2004], requires students enrolled in health-related courses, which will involve direct patient contact in medical or dental care

facilities to **complete a three dose series of hepatitis B vaccine prior to direct patient care**. This rule applies to all medical interns, residents, fellows, nursing students, and others who are

being trained in medical schools, hospitals, and health science centers and students attending two-year and four-year colleges whose course work involves direct patient contact regardless

of the number of courses taken, number of hours taken, and the classification of student.

Website for Texas Department of State Health Services Adult Immunizations Schedule: http://www.dshs.state.tx.us/immunize/adult\_sched.shtm

**Please check one of the following boxes as it applies to your Hepatitis B series:**

I have completed the Hepatitis B 3 shot series



I only have 1 shot remaining of the 3 shot series: 3rd shot due \_\_\_\_\_\_\_\_\_\_\_\_\_

I have completed my first shot and the dates for the next two shots are:

\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_

***Based upon the clinical/extern site rules and regulations I understand & acknowledge that if I have not completed the Hepatitis B 3 shot series, I may not be able to participate in the clinical/externship portion of the program.***

I have read and understand the Texas Department of State Health Services policy on Hepatitis B vaccine series. https://www.dshs.state.tx.us/immunize/docs/school/hepB\_Policy.pdf



**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Documenting History of Illness: Varicella (Chickenpox)**

This form summarizes the “**Exceptions to Immunization Requirements (Verification of Immunity) for Varicella (Chickenpox)**.”

A report of the serologic confirmation of varicella immunity (positive varicella IgG result – titer) is acceptable in lieu of a vaccine record for the disease. BAP Life Support shall accurately record the results of any serologic tests supplied as proof of immunity. If a student is unable to submit such a statement or serologic evidence, varicella vaccine is required.

**Documentation of prior varicella illness can be provided by the following methods:**

1. A serologic confirmation of varicella immunity (positive varicella IgG result).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name of person completing form) (Signature of person completing form)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Relationship to student) (Date)



For more information about Varicella contact:

Texas Department of State

Health Services

Immunization Branch

(800) 252-9152 [www.ImmunizeTexas.com](http://www.immunizetexas.com/)