WEST HILLS COLLEGE COALINGA | Health Careers

300 Cherry Lane ▪ Coalinga, CA 93210 ▪ 559-934-2760

NURSE ASSISTANT TRAINING PROGRAM (NATP/CNA)

APPLICATION FOR ADMISSION

The documents listed herein are required to be submitted in their entirety, completed and signed where applicable.

No application will be accepted unless or until all documents have been verified as being correct and current.

Applicants are considered on a first come first served basis.

DEADLINE TO SUBMIT APPLICATIONS:

April 23rd, 2019 – May 10th, 2019 DEADLINE BY NOON (NO EXCEPTIONS!!!)

Questions may be directed to Amy Martinez, Senior Secretary, CTE
Phone: (559) 934-2236

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NATP COST ESTIMATES

The student is responsible for the cost of all needed supplies and materials for this program. The following is the ***estimated cost*** of all supplies that are required for each student.

ITEM	ESTIMATED COSTS
Background Check and Drug Screen American Data Bank	$90
Live Scan	$69
Tuition Fees @ $46/unit for 6 units **(Payable in Administration Office Only)**	$276
Physical & TB Test (Prior to Admission)	$160
NATP Textbook & Workbook – *Hartman's Nursing Asst. Care (Long-Term Care) 2nd Ed.*	$75
Classroom Supplies	$30
Watch with Second Hand	$30
Uniform (2 Sets)(See Dress Code)	$90
White Nurse Shoes (See Dress Code)	$75
State Certification Test (Due 3 weeks prior to class ending) **Students will we required to drive to Delano for testing. More information will be provided.**	$100
CPR Card (American Heart Association Only)(Due 1st Day of Class)	$65
Blood Pressure Cuff	$25
Stethoscope	$60

Approximate Total Cost: $1,145

Clinical hours locations TBD.

All costs are approximate and may be more or less than the amount shown above.

West Hills College Coalinga (WHCC) does not sponsor students to sit for the State Certification Test. Any and all fees for the Department of Public Health Services and American Red Cross/American Heart Association (written and skills exams) are the responsibility of the student.

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APPLCATION INSTRUCTIONS – Nurse Assistant Training Program

Students are selected on a first come-first serve basis and applications must be submitted in their entirety before a student will be accepted into the program.

All of the following documentation *MUST* be submitted in order for your application to be considered complete:

1. **Program Application:**
    - **Form A:** Nurse Assistant Training Program Application
    - **Form B:** Student Demographics Sheet
    - **Form C:** West Hills College Release of Information
    - American Data Bank (ADB) Disclosure and Release Form
    - Clearance Certification
    - **Form D:** Health Examination Form (Required AFTER accepted into program.)
    - **Form E:** Emergency Treatment Consent
    - **Form F:** Private Vehicle Authorization

2. **Copy of TB Test and Results (Valid for only 6 months)**
    - **If you have a history of positive TB test results, please provide an updated copy of your chest x-ray, (valid for only one (1) year). *Required AFTER accepted into program.**

3. **Copy of Valid Driver's License or State ID**
4. **Copy of Signed Social Security Card**
5. **Copy of High School Diploma (or GED) or Proof of Equivalency (i.e. AS Degree)**
6. **Proof of Valid Vehicle Insurance**
7. **Copy of valid CPR Card: No on-line courses accepted. The CPR course must only be through the American Heart Association, (BLS for Health Care provider). You can contact the American Heart Association at: 1-800-AHA-USA-1 to find a location near you. (Must be acquired prior to first day of class.)**

8. **You will be provided background check and drug clearance information after you are accepted into the program.**

9. **Copy of American Data Bank Background Check and Drug Screen clearance receipts:**
    - **Once you have completed the Background portion, you should receive a confirmation email with a reference number on it. Print that page and bring it in to our office as soon as you complete it along w/ your completed application and all required documentation. We will then release to you the Chain of Custody form and give you instructions on how to complete the Drug Screen portion of your background. *You will only have 48 hours to complete the drug screen portion after finishing the Background Report.**

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A

Nurse Assistant Training Program Application (NATP/CNA)

Semester______Year________

Name____ Legal Last Name
First Middle Social Security Number

*WHC Email:____________________________________@my.whccd.edu *Student ID # ________________

Mailing Address____
Number and Street City State Zip Code

Primary Phone _____________________ Secondary Phone ____________________ Birth Date: ______________

CA Resident______year(s) CA Driver's License #______________________ Birth Certificate (if no DL) ☐

High School Graduate: Yes ☐ No ☐ GED ☐ Are you currently enrolled with another College? Yes ☐ No ☐

Name of College:______________________________ Location of College: ______________________________

Have you previously attended West Hills College? Yes ☐ No ☐ Year(s) Attended ___________

VETERAN: Yes ☐ No ☐

The final responsibility for the completeness and accuracy of this application packet rests with the applicant.

I hereby affirm under penalty of dismissal that all information supplied in this application is complete and accurate.

____ ____________________

Applicant Signature **Date**

Student ID# ______________________

*This information is required.

B

WEST HILLS COLLEGE COALINGA

Nurse Assistant Student Demographics Sheet

Name: ____

Social Security #______________________________WHCC ID#__________________

Primary Language:____________________Additional Languages: __________________

Birth date: _______________

Date Entered Program:_________________Date Expected to Graduate: _____________

1. Age: (a) 18-25 (b) 26-35 (c) 36-45 (d) 46-55 (e) >56 (f) Info not available

2. Ethnic Background: (a) Native American (b) Asian or Pacific Islander
(c) African American (d) Filipino (e) Hispanic (ab) White, non-Hispanic (ac) Other
(ad) Unknown

3. ESL (English as a Second Language)?________Yes ______No

4. Gender: Male________(a) Female______(b)

5. Do you receive financial aid? Yes___(a) No___(b)

   Type (BOGG waiver, Workforce, etc.)____

6. Are you currently employed?______Yes________No W h e r e ? ______________________________

FOR OFFICE USE ONLY

TEAS VERSION:____ Date Taken:______________ Adj. Score:__________%

Rdg________% Math________% Science________% English________%

Prerequisite GPA:__________

Cumulative GPA:__________

Total Points:__________

Start Date:__________ Cohort: Class of__________

C

West Hills College Coalinga
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RELEASE OF INFORMATION

Personally identifiable information from educational records cannot be released without the prior written consent of the student, except as specified under the provisions of FERPA (Family Educational Rights and Privacy Act of 1974).

The West Hills College Coalinga Health Careers Office is required by its contracts with various health facilities for clinical placements with clinical and community institutions to provide certain personal information to the agency. The release of information is required in order to allow you to receive your clinical experience. The clinical agencies are required to have certain information because of JACHO accreditation and other Federal requirements.

It is therefore necessary for you to provide your clinical instructor a Release of Information form when you give her/him the immunizations, TB test results, malpractice insurance information, etc. as requested by each clinical agency.

By signing this form you are giving the school and WHCC Health Careers or its representative such as your clinical instructor, the right to provide your personal and academic information to the agency in need of specific information necessary for your clinical rotation. This includes the release of your grades on a pass/fail basis and for any safety issues that might arise.

Name of Student: ________________________________
Please print your name

Name of Student: ________________________________
Please sign legibly

Date: ________________________________

Student ID Number: ________________________________

C2

Clearance Certification

I_____________________________, certify that I have no criminal offenses on my personal record.

Print First & Last Name

I understand that if the ADB background check report reveals past activities that make me ineligible, I will be terminated from the WHCC Allied Health Careers Nursing Assistant Training Program.

___________________________________ ____________________ ________________

Student Signature WHCC ID# Date

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D

Certified Nurse Assistant Health Examination Form

Dear Doctor:
The individual listed below is applying for the Medical Assisting Program. As per California regulations, a physical must be completed prior to entering the program. Please fill out the following form regarding physical health and identify any possible limitations.

Student's Name: ____ Date: ____________________
Have you had any of the following complaints?

Yes	No	Yes	No	Yes	No	Yes	No
□	□ Headaches	□	□ Blackouts	□	□ Joint pain	□	□ Hay fever/asthma
□	□ Dizziness	□	□ Unconsciousness	□	□ Chronic fatigue	□	□ Shortness of breath
□	□ Frequent colds	□	□ Diarrhea	□	□ Chest pain	□	□ Difficult urination
□	□ Hoarseness	□	□ Nausea/Vomiting	□	□ Palpitations	□	□ Nighttime urination
□	□ Tarry Stools	□	□ Enlarged glands	□	□ Excessive thirst	□	□ Sleeplessness
□	□ Indigestion	□	□ Excessive gas	□	□ Ankle swelling	□	□ Anxiety attacks
□	□ Constipation	□	□ Blood in Stools	□	□ Night sweats	□	□ Yellow jaundice
□	□ Cold feet						

If you answered yes to any of the above conditions, please explain:
____
____
____
How many pillows do you use?______What major operations have you had? ____
____
I grant permission to the below signed physician or representative to release this information to West Hills College:

____
Student Signature Date

Physical Assessment

EENT ___________________________ Urinary__________________________
Cardiovascular____________________ Muscular_________________________
Respiratory______________________ Skeletal__________________________
GI_____________________________ Neuro___________________________
Allergies ________________________ Medications ______________________

TB Skin Test

Date of TB skin test_________Results_________Date Read____________Read by _____________

Physical Requirements - Please check the following tasks the individual is able to perform:

Lift, push or pull objects weighing 50 lbs □ Stand and walk without difficulty □
Stand for long periods of time □ Bend at the waist without difficulty □
Perform basic range of motion □ Limitations, if any: ________________________________

____ ________________________
Signature of Physician **Date**

E

Emergency Treatment Consent

I,________________________________, give my permission and consent for emergency treatment, in the event of an accident or sudden illness, by the staff of any and all hospitals while using the clinical facilities of a specific hospital as assigned by the WHCC Health Careers Office while a student of WHCC.

I DO ____ Or I **DO NOT** _____ Give my permission for the administration of blood when prescribed by a physician.

______________________________	____________________	________________
Student Signature	WHCC ID#	Date

IN CASE OF EMERGENCY, contact the following:

Name______________________________	**Name**______________________________
Relationship________________________	**Relationship**________________________
Phone-residence____________________	**Phone-residence**____________________
Phone-cell _________________________	**Phone-cell** _________________________

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F

Use of Private Vehicle Authorization for School Transportation

Student's Name_____________________________WHCC ID#_________________Date ______________

I. INFORMATION ON VEHICLES:

Make or Model:___________________________ Vehicle License # ______________________

Registered Owner: ____

Address of Registered Owner: ____

Name of Driver:__________________________________ Driver's License #: ________________

Name of Insurance Company: ____

Type of Insurance: (Mark all that apply)

Public Liability ☐ Property Damage ☐ Medical Coverage ☐ Collision ☐

ATTACH A PHOTOCOPY OF CURRENT INSURANCE CARD OR PROOF OF INSURANCE WITH THIS FORM.

II. STATEMENT

I understand that if I fail to provide evidence of a current driver's license and/or current vehicle insurance, I am not authorized to drive.

☐ **I WILL be driving** ☐ **I WILL NOT be driving**

____ __________________________

Student Signature Date