NURSE AIDE

BENEFITS

- Outstanding clinical opportunities
- Expert faculty provide individual support in small class settings

ADMISSION REQUIREMENTS

- Program Application
- Proof of legal residency
- Photo I.D.
- Criminal Background Check
- Completed Medical Packet
- Payment of fees

PROGRAM SUMMARY

The 11-week Nurse Aide Program prepares the student to take the State Tested Nurse Aide examination. The program consists of 66 hours of classroom instruction and 16 hours of clinical instruction. The class meets Tuesday and Thursday, 6:30 pm to 9:30 pm at the fort Hayes Career Center located at 546 Jack Gibbs Boulevard. Columbus, Ohio 43215.

START DATE	END DATE	APPLICATION DUE	TUITION
07/19/22	09/29/22	07/15/22	$960*
09/06/22	11/17/22	09/02/22	$960*
01/03/23	03/16/23	12/30/22	$960*
04/18/23	06/29/23	04/07/23	$960*

*Other costs include scrubs, physical, background check and state test.

Financial assistance may be available through Ohio Means Jobs-Franklin County at 1111 E. Broad Street. Columbus, Ohio 43205. Their phone number is 614.559.5052. Assistance may also be available though the Short Term Certificate Grant program

Contact Matthew Kramer with questions
mkramer6324@columbus.k12.oh.us
380.997.7615

COLUMBUS CITY SCHOOLS
Adult &Community Education

CCS ACE 22-23 STNA Enrollment/Registration Checklist

ACE Adult Workforce Education application	
ACE 2022-2023 Student Information form	
Photo ID (Valid driver's license or state ID)	
Social Security card	
Release of Information form	
ACE Criminal History Attestation form	
FBI/BCI Background check	Receipt ___ Report ___
ACE Personal Medical History form	
Physical Examination form	
Mantoux 2-step or chest x-ray	
Evidence of COVID vaccination(s)	
Proof of tuition payment (if applicable)	

ADULT WORKFORCE EDUCATION

Program Application 2022-2023

Please review the application checklist to make sure you
have attached all required documentation prior to submitting your application.
Incomplete application packets will not be accepted.

Program:
☐ Nurse Aide ☐ Other _____
☐ I am a new student.
☐ I am a returning student: last month/year of attendance _____

Today's Date: _____Program Start Date: _____
Name:
Last: _____ First: _____ Middle Name: _____
Social Security Number: _____ - _____ - _____ Birth Date: _____

E-Mail: _____
Street: _____ City: _____ Zip: _____
Cell Phone: ( ) _____-_____

- *We reserve the right to reschedule or cancel any course that does not meet our minimum enrollment requirements. If a course is cancelled or rescheduled, all fees paid are subject to reimbursement or transference, upon presentation of a receipt.*

- The Columbus City Schools do not discriminate based upon sex, race, color, national origin, religion, age, disability, sexual orientation, gender identity/expression, ancestry, familial status, or military status with regard to admission, access, treatment or employment. This policy is applicable in all district programs and activities.

Signature: _____ Date: _____

Student Information Form 2022-2023

Please print neatly and complete all questions!

Program: Nurse Aide **Start Date**: **Returning student?** Yes/No Date last attended: _____

Is this your first time enrolling in school since your high school graduation or GED completion? Yes ___ No ____
Is your enrollment at this school within 1 year of your high school graduation or GED completion? Yes___ No___

First Name: _____Middle Name: _____Last Name:_____

Social Security Number: _____ **Date of Birth:** _____ **Gender**: ☐ Male ☐ Female

Race: ☐ Native American ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Multi-racial
☐ Native Hawaiian or Other Pacific Islander ☐ White

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Cell Phone : _____**Other Phone:** _____

E-Mail:_____

Emergency Contact Name & Phone: _____

High School Education:
☐ **GED** year received _____

☐ **Ohio High School Diploma:** Year Graduated _____ School Name _____

☐ **Out-of-State High School Diploma** : Year Graduated _____ School Name _____

Have you previously attended college? ☐ Yes ☐ No

Please check all that apply:
☐ **Disadvantaged**: I am facing barriers to employment ***and/or*** I have qualified or expect to qualify for financial assistance based on need.
Check all that apply: ☐ TANF ☐ Pell Grant ☐ WIOA ☐ Federal Subsidized Stafford Loan

☐ **Displaced Homemaker**: I have been a homemaker but can no longer depend on the income of the family members in my household.

☐ **Limited English Proficiency**: English is not my first language.

☐ **Nontraditional Training and Employment** I am a man entering a typically female-dominated field, or I am a woman entering a typically male-dominated field.

☐ **Single Parent**: I am a single parent caring for my child in my home.

Signature: _____ **Date**: _____

Ohio | Department of Higher Education

John R. Kasich, Governor
John Carey, Chancellor

Release of Information Form

I, (print name) _____, authorize the Ohio Department of Higher Education to release my educational records, which includes my name, social security number, student ID number, address, job placement records and job retention records to the agency listed below. The agency use of these records is limited to and in connection with the audit and evaluation of Federally-supported education programs, or in connection with the enforcement of the Federal legal requirements, which relate to such programs.

Student/Examinee information released to:

Ohio Department of Job and Family Services
145 South Front Street
Columbus, Ohio 43215

Ohio Department of Higher Education
25 South Front Street, 7 FL
Columbus, Ohio 43215

My signature is my acknowledgement that I have read and voluntarily consented to the release of the above-mentioned education records as collected and utilized by the Ohio Technical Center (OTC) program I have previously enrolled or tested with.

Social Security Number or Security Number * ☐☐☐ - ☐☐ - ☐☐☐☐

_____ _____

Signature of Student/Examinee **Date**

* **Use of Social Security Number is optional. If you choose to give us your Social Security Number, we will use it to maintain your file and assure prompt and accurate reporting.**

(Revised 11/04/2015)

Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

CRIMINAL HISTORY FACT SHEET

Currently, there are eleven offenses that are *automatic bars* to obtaining a nursing license for applicants who entered a prelicensure nursing education program after June 1, 2003. This means that the Board of Nursing (Board) is prohibited from issuing a license to a person who has pled guilty to, been convicted of, or has a judicial finding of guilt for one of the offenses listed below.

•Aggravated Murder • Murder • Voluntary Manslaughter • Felonious Assault •Kidnapping • Rape • Aggravated Robbery • Aggravated Burglary • Sexual Battery • Gross Sexual Imposition • Aggravated Arson • or a substantially similar law of another state.

In addition, the Board may propose to deny an application, or place restrictions on a license granted, for a conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for the following: (1) any felony (that is not an absolute bar); (2) a crime involving gross immorality or moral turpitude; (3) a misdemeanor drug law violation; or (4) a misdemeanor in the course of practice. **In regard to these four types of offenses, the Board is unable to advise or give a definitive answer about the effect a criminal history will have on the ability to obtain a nursing license in the State of Ohio.**

The Board does not have the authority to make a determination or adjudication until an application has been filed. If an applicant has a criminal history, the Board conducts a thorough investigation and considers a number of factors, including but not limited to: whether the applicant has made restitution, completed probation and/or otherwise been rehabilitated; the age of the offense; the facts and circumstances underlying the offense; and the total number and pattern of offenses.

Please also be advised that although the Board may grant a license to an applicant who has a criminal offense history, an individual may be restricted from working in certain settings based on his or her criminal history due to federal and state laws, which require criminal records checks prior to employment in certain settings, and which may impose absolute or discretionary bars to employment in certain patient care settings, for example, in facilities or settings involving care provided to older adults, disabled adults, or children. *See, e.g., Ohio Administrative Code Chapters 3701-60-07; 173-9-07; 5101:3-45-11; 5123:2-2-02; 5101:3-45-11.*

Similarly, the Board cannot answer questions regarding one's eligibility to attend nursing school or participate in clinical instruction. Nursing programs vary in regard to enrollment criteria, so it is recommended that you contact the nursing program to determine whether you are eligible to enroll.

CRIMINAL HISTORY ATTESTATION

We are committed to student success and want to make all applicants aware of some very important information that could impact one's ability to graduate from the program.
Please read this form carefully before signing it.

Please check **ONE** statement below:

☐ I have NEVER been convicted of, pled guilty to, or have had a judicial finding of guilt for a crime as identified in the Ohio Board of Nursing CRIMINAL HISTORY FACT SHEET or,

☐ I HAVE been convicted of, pled guilty to or have had a judicial finding of guilt for a crime that is an automatic bar, as identified on the Ohio Board of Nursing CRIMINAL HISTORY FACT SHEET.

The Ohio Board of Nursing may also deny an application for a license or place restrictions on a license for other offenses that may not be automatic bars to licensure. All applicants are advised that they should carefully review the four other types of offenses listed on the CRIMINAL HISTORY FACT SHEET for which the Ohio Board of Nursing may take action. The Department of Adult and Community Education does not assume any responsibility or liability for the denial of an application or any restrictions that may be placed on a license by the Ohio Board of Nursing.

Please be aware that some programs have required clinical/job shadowing experiences in order to obtain a certificate and graduate from the program. A clinical/job shadowing site may request that a student provide their criminal history in order to participate at the clinical/job shadowing site. Most sites have policies which prevent them from admitting students who have been convicted of certain criminal offenses. Decisions about clinical/job shadowing site admissions are made by each site. These decisions are neither the responsibility of nor influenced by the Department of Adult & Community Education.

If a student is unable to gain admission to a site for clinical/job shadowing experiences, the student will not be able to obtain their certificate nor graduate from the program. If a student is denied admission to a site, the student will be subject to immediate dismissal from the program and will forfeit all program costs and fees. The Department of Adult & Community Education does not assume any responsibility for the denial of access to a clinical/job shadowing site.

By signing this form, I acknowledge **ALL** of the following:

- I have neither withheld information from nor provided false information to the Department of Adult & Community Education.
- I have been informed regarding the requirement to complete clinical/job shadowing site experiences in order to obtain my certificate and graduate from the program.
- I have been informed that access to clinical/job shadowing sites may be denied to students with criminal convictions.
- I understand that if I am unable to complete clinical/job shadowing experiences, I will be subject to immediate dismissal from the program and will forfeit all program costs and fees.
- I understand that if I have pled guilty to, been convicted of or have had a judicial finding of guilt for a criminal offense which is an automatic bar to licensure by the Ohio Board of Nursing, I will not be granted a nursing license by the Ohio Board of Nursing.

_____ _____

Applicant Signature Date

Medical Packet (1 of 5)
Personal Medical History

Complete this form prior to your physical examination and give it to the doctor for review.

Name: _____ **Date of Birth:** _____

Street: _____ **City/State:** _____ **Zip:** _____

Phone: _____-_____-_____ **E-mail:** _____

Height: _____ **Weight:** _____ **Gender:** ☐ Male ☐ Female

Check the appropriate column for each body system or condition, based on your personal medical history:

	YES	NO		YES	NO		YES	NO		YES	NO
Neurological			Lymph nodes			Chest pains			Malaria		
Eyes			Genitals			Chest Palpitations			Rheumatic fever		
Ears			Dizziness			Shortness of breath			Paralysis		
Nose			Frequent headaches			High blood pressure			Cancer or tumors		
Throat			Deafness			Swollen ankles			Jaundice		
Heart			Runny nose			Poor appetite			Diabetes		
Lungs			Frequent sore throats			Chronic indigestion			Arthritis		
Stomach			Frequent colds			Recurrent nausea			Rheumatism		
Intestinal			Chronic cough			Recurrent vomiting			Depression		
Liver			Difficulty Breathing			Stomach ulcers			Nervous breakdown		
Spleen			Coughing up blood			Hernia			Seizures		
Gallbladder			Sinus			Chronic constipation			Major injuries		
Kidneys			Pneumonia			Black or bloody bowel movements			If so, what?		
Bladder			Asthma			Frequency or Painful urination			Allergies		
Bones			Hay fever			Bloody urine			List allergies:		
Joints			Pleurisy			Kidney stones			Operations		
Back			Tuberculosis			Nephritis			List operations:		
Skin			Bronchitis			Mental illness					

Medical Packet (2 of 5)

Personal Medical History continued

Name: _____

Please do not leave any boxes blank. If a question does not apply to you, please mark with N/A.

List any serious conditions or illnesses that could affect your ability to perform as a health occupations student.

Describe the details of any prior injuries or operations that could affect your ability to complete the classroom, laboratory, and/or clinical components of the program.

What accommodations do you need in order to perform the functions of a health occupations student?

Do you have any sensitivity to rubber, latex, or powder? ☐Yes ☐ No

By signing below, I hereby attest that I have answered the above questions thoroughly and truthfully, to the best of my knowledge.

Signature: _____ **Date:** _____

Medical Packet (3 of 5)

Physical Examination

This form must be completed by a qualified medical professional (M.D., D.O., or N.P.).
Do not substitute other forms or formats.

Patient's Name: _____ **Date:** _____

Record of Physical Examination

Height		Weight	
Blood Pressure		Rate of Respiration	
Pulse		Visual Acuity	
Eyes/Pupils		Hearing	
Ears		Mouth/Dental	
Nose		Heart	
Neck		Abdomen	
Lungs		Back	
Extremities		Hips	

Tuberculosis: Documentation of one of the three options below is required:

2-step Mantoux Tuberculin Skin Test (Submit dates and results of both steps)

2-step Mantoux Skin Test for Tuberculosis

Step #1: Inject Tuberculin and read in 48 to 72 hours. If positive, omit step #2, and obtain chest x-ray.

☐ **Mantoux Step #1**: Date given _____ Given by _____ Skin site _____
Date read _____ Read by _____Result _____

If Step #1 is negative, wait 7-21 days and proceed with step # 2.

☐ **Mantoux Step #2**: Date given _____ Given by _____ Skin site _____
Date read _____ Read by _____Result_____

OR

☐ **Chest x-ray**: Must be within the last year. Date given _____ Given by _____
Date read _____ Read by _____ Result_____

OR

☐ **IGRA Blood test:** Date given _____ Given by _____
Date read _____ Read by _____ Result_____

Medical Packet (4 of 5)
Physical Examination continued

Physician's Certificate

This certifies that I have examined this patient with regard to his/her physical fitness to attend a health occupations education program. To the best of my knowledge, this individual is physically and mentally capable of pursuing a health occupations career as indicated below.

☐ **Endorsed without limitations.**

☐ **Endorsed with the following limitations:** _____

☐ **Not endorsed for the following reasons:** _____

Physician's Signature: _____ **Date:** _____

Printed Name and Title _____

Address_____

_____

Phone Number/Fax Number_____

Medical Packet (5 of 5)
Hepatitis B Immunization

General Information

A highly contagious virus that infects the liver causes Hepatitis B. The virus is found in the blood and body fluids of infected people. Safe, effective Hepatitis B vaccines are recommended for health care professionals because of their exposure to blood and body fluids. The vaccination series, generally given as 3 doses over a 6-month period, protects those at risk and contributes to the elimination of Hepatitis B. The Hepatitis B vaccine is recognized as the first anti-cancer vaccine because it can prevent liver cancer caused by Hepatitis B infection. Hepatitis B vaccine is safe and effective. The potential risks associated with the Hepatitis disease far outweigh the potential risk associated with the Hepatitis B vaccine.

Section I

I understand that I have the opportunity to ask questions and that I understand the benefits and risks of the Hepatitis B immunization. I understand that I must have three (3) doses of the vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I understand that, due to my occupational exposure as a health professional to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B. I understand that I may choose to be vaccinated with the Hepatitis B vaccine at my own personal expense.

Printed Name_____ **Signature:** _____

Date: _____

Complete Section I (above) and *either* Section II or III (below).

Section II

I refuse to receive the Hepatitis B vaccination at this time. I understand that, by refusing to receive this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. If I decide to receive the vaccine at a later date, I will provide the Columbus School of Practical Nursing with the information.

Printed Name: _____

Signature: _____ **Date:** _____

OR

Section III

I have received the Hepatitis B vaccination.

Printed Name:_____

Signature: _____ **Date:** _____The following information must be provided by a qualified medical professional or his/her representative if you have received the Hepatitis B vaccination:

Date of Dose #1: _____**Date of Dose #2:** _____ **Date of Dose #3:** _____

Physician Name/signature