1/30/2025

Nurse Aide Training Program

Program Summary: The 10-week Nurse Aide program prepares the adult student to take the Ohio State Tested Nurse Aide examination. The program consists of 64 hours of classroom instruction and 16 hours of clinical instruction.

Class meets on Tuesday and Thursday evenings from 5:30 pm to 8:30 pm.

Class Location: Adult & Community Education, Columbus City Schools
2323 Lexington Avenue, Columbus, OH 43211

Course Benefits:
- Outstanding clinical opportunities
- Expert teaching staff provide individual support in small class settings
- Assistance with job placement and resume

Cost: **$1264 total** = $1064.00 tuition + $200 other costs

Other costs include (costs are approximate*):
- $25* Navy blue scrubs
- $75* FBI/BCI background checks
- $100* Physical exam and TB testing

Registration Requirements:
- Complete program application
- Provide proof of legal residency and photo identification
- Complete FBI/BCI criminal background check
- Complete medical packet including a physical examination and TB test

Important Dates**

Class Instruction Dates	Application Due Dates	Clinical Dates	State Exam Date
04/29/25 to 07/08/25	Friday 04/11/25	07/12 & 07/13/25	Sunday 07/20/25

** Dates and times for course are subject to change and are dependent upon sufficient staffing availability.

For more information or questions, please contact Michael Harvin at mharvin@columbus.k12.oh.us or at 380-997-5904.

Adult & Community Education improves the lives of adult students through personalized, quality learning.

Adult & Community Education 2024 – 2025
Nurse Aide Enrollment/Registration Checklist

ACE 2024-2025 Nurse Aide application	
Photo ID (Valid driver's license or state ID)	
Social Security card	
Criminal History Attestation form	
FBI/BCI Background check Code: 4723.09 Background check results are to be sent to: Michael Harvin, Columbus City Schools Adult & Community Education. 2323 Lexington Avenue Columbus, Ohio 43211	Receipt _____ Report _____
ACE Personal Medical History form	
Physical Examination form	
Mantoux 2-step or chest x-ray	
Hepatitis B Waiver Form	
Proof of tuition payment (when applicable)	

Adult Workforce Education
Program Application 2024-2025

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 as it appears on ID: _____

Last Name: _____ **First Name:** _____

Middle Name: _____ Other Names (Maiden)_____

Social Security Number: _____ - _____ - _____ **Birth Date:** _____

E-Mail: _____

Street: _____ **APT #** _____

City: _____, OH **Zip:** _____

Cell Phone: ( ) _____-_____
Have you previously attended college or a post-secondary school? Yes ___ No ___

- *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 Board of Education does not discriminate based upon race, sex, sexual orientation, religion, color, national origin, age, gender identity or expression, ancestry, familial status, military status, disability, genetic information, or any other legally protected category (collectively, "protected classes") in its educational programs, activities, treatment of people and employment practices.

Signature: _____ **Date:** _____

1/30/2025

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

1/30/2025

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 to be completed by qualified medical professional:

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

Medical Professional'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.

MUST BE CHECKED BY PHYSICIAN:

☐ **Endorsed without limitations.**

Physician's (M.D., D.O, or N.P.) Signature: _____**Date:** _____

Printed Name and Title_____

Address_____

_____

Phone Number/Fax Number_____

Medical Packet (4 of 5) Immunization Documentation

Name: _____

Tuberculosis (TB):

Documentation of one of the three options below is required:

2-step Mantoux Tuberculin Skin Test

Step #1: Inject Tuberculin and have **read in 48 to 72 hours.**

☐ **Mantoux Step #1**:

Date given_____ Given by_____ Skin Site _____
Date Read _____ Read by _____ Result _____

If Step #1 is **negative,** wait 7-21days AFTER the read date and proceed with step # 2.
Do not start Step #2 outside of the 7-21day window.
If Step #1 is **positive,** omit step #2, and obtain chest x-ray.

☐ **Mantoux Step #2**:

Date given_____ Given by_____ Skin Site _____
Date Read _____ Read by _____ Result _____

OR

☐ **Chest x-ray**: Must be within the last year. Printout of results must be provided.

OR

☐ **IGRA Blood test:** Must be within last year. Copy of IGRA results must be provided.

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. The potential risks associated with the Hepatitis disease far outweigh the potential risk associated with the Hepatitis B vaccine.

Signature Required in ONE of the boxes below:

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.

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

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.

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 with a printout as documentation, if you have received the Hepatitis B vaccination:

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

Physician Name/signature_____