LOS ANGELES MISSION COLLEGE

13356 ELDRIDGE AVENUE
SYLMAR, CA 91342

Dear Applicant,

Thank you for your interest in the Nurse Assistant & Home Health Aide Training Programs (NATP-HHP). Attached, you will find all of the information you will need in order to become eligible to apply:

- Student Resource & Information *(pages 2-3)*
- NATP-HHP Student Application Checklist *(page 4)*
- Los Angeles Mission College NATP-HHP Admissions Application *(page 5)*
- Los Angeles Community College District Health Record *(pages 6-7)*
- Influenza Vaccination Declination Form *(page 8)*
- Allied Health 021 Course – CPR Card Fee Form *(page 9)*
- Arthur Rupe Reimbursement/Tuition Assistance Application *(page 10)*
- CDPH 283B / Certified Nurse Assistant (CNA) Initial Application Form *(available online)*
- CDPH 283D / Home Health Aide (HHA) Initial Application Form *(available online)*
- Evidence of Understanding from Student Handbook *(available online)*
- NATP-HHP Schedule *(available online)*

Please review the information in this packet. If you have any questions please contact Aracely Molina.

Deliver the application and required documents to:

ARACELY MOLINA
CNA FACULTY & PROGRAM DIRECTOR
INST FACULTY OFFICE ROOM # 13
INSTRUCTIONAL BLDG. *(1ST FLOOR)*
LAMC MAIN CAMPUS
818-833-3436
molinaa2@lamission.edu
www.lamission.edu/~molinaa2
www.lamission.edu/Allied-Health

Sincerely,

Aracely Molina
CNA Faculty & Program Director

STUDENT RESOURCE & INFORMATION

Fingerprinting/Background Check
You will be required to bring a valid photo identification (i.e. Driver's License, State ID card, or Passport) for Live Scan Fingerprinting. Live Scan Fingerprinting will be done **in class**, provided at no cost to the student.

Malpractice Insurance
Please provide us the proof of your insurance. You can obtain malpractice insurance from Nurses Service Organization at https://www.nso.com/ *-or-* 1-800-247-1500. Choose "California" as state of residence, select "Nursing Assistant" and select "student" to apply. *[See instructions on page 3.]*

Scrubs and Name Tags
The required uniform is light blue scrubs with Los Angeles Mission College logo; no designs or other colors permitted. Also required: Nurse Assistant Student name tag holder. Obtain the scrubs and name tags from LAMC Bookstore.

LAMC Student Identification Card
Required for use with name tag holder. Obtain your LAMC Student ID card from the Business Office. *Students are required to pay their fees before obtaining an ID card. If students have applied for Financial Aid, the Financial Aid Office usually disburse tuition funds before the semester starts. Students must apply in advance to avoid delay in processing.*

Immunizations, Physical Examinations, and Drug Screens
If you have an immunization card, this will have many of the required vaccinations listed. The physical examination, drug screen and remaining immunizations or titers can be obtained from your personal physician or by contacting the resources below:

- **LAMC Student Health Center:** http://www.lamission.edu/healthcenter/ - Please contact them for more information and making appointments! *[Physical, Drug Testing, Etc.]*
- **WellnessMart**: http://wellnessmart.com/ - Contact them for details! *[Physical, Drug Testing, Etc.]*
- **Foundation Laboratory:** http://foundationlaboratory.com/services.html *[Drug Testing]*
    - Foundation Laboratory (Northridge - PSC 135)
        - 17075 Devonshire Blvd. #104 Northridge, CA 91325
        - Phone: (818) 360-7200
        - M-F: 8:00 AM to 4:30 PM. Sat: Closed. Lunch: 12:30 to 1:00 PM.
    - Foundation Laboratory (Northridge - PSC 136)
        - 18251 Roscoe Blvd. Northridge, CA 91324
        - Phone: (818) 341-1405
        - M-F: 8:30 AM to 5:00 PM. Sat: Closed. Lunch: 1:00 to 2:00 PM.
- **Express Collections** *[Drug Testing]*
    - (Quest Diagnostics, *Site Code: CC590*):
        - https://secure.questdiagnostics.com/hcp/psc/jsp/ViewPSCDetails.do?siteCode=CC590
        - 8780 Van Nuys Blvd. Ste C, Panorama City, CA 91402
        - Phone: (818) 891-2235

Malpractice Insurance Instructions

- Please provide us the proof of your insurance.
- You can obtain malpractice insurance from **Nurses Service Organization**
  - Go to: http://www.nso.com/. (Phone #: 1(800) 247-1500).
  - On the top left of the page, next to the NSO logo, click on the first tab [**Get Insurance**].
    - Select [**Professional or Student**] submenu.
  - A webpage with [**Select your profession**]/[**Select One**] dropdown menu will appear.
    - Select <**Student**>.
  - A webpage titled **NSO malpractice insurance for Student Nurses** will open.
    - On the right-hand-side of the webpage, under **Ready?** icon,
      - click on [**Get a quick quote**] button.
  - A webpage titled **Looking for a quick quote?** will open.
    - Click on [**Professional or Student**] icon.
  - A webpage titled **Quick Quote for Individual Professional Liability Insurance** will open. Complete the following steps:
    - 1. State of residence: Select <**California**>
    - 2. Select your profession or area of study: Select <**Nursing Assistant**>
    - 3. Are you a member of professional association?
      - If you are not, select "**No**." If you are, select "**Yes**."
    - 4. Select your status as a healthcare professional: Select [**Student**]
    - Graduation Date: (The last day of classes for the semester. See your schedule.)
    - [**Continue**]
  - A page with "**Quote Details**" will open.
    - Select [**Complete Your Online Application**].
  - An **Online Application** webpage will open.
    - Complete the application.
    - For **Requested Effective Date of Coverage**, input the first available date before and closest to the date of the first day of class (see your schedule).
    - [**Continue**]
  - Follow the instructions on subsequent pages until your application is complete.
  - A confirmation e-mail of your application will be sent to you by NSO.
  - Within a few days, you should receive your NSO **Certificate of Insurance** as a pdf. Print this document and attach it to this application (must be completed) along with the rest of the required documents.

NURSE ASSISTANT & HOME HEALTH AIDE TRAINING PROGRAMS
STUDENT APPLICATION CHECK LIST

Student Name: _____ **Semester:** _____

Students must have all of the following items present in their student file to be eligible to participate in the program.
Students must provide a specific number of copies of documentation as indicated.
Students must keep their own copy for their records.

☐ Must be officially enrolled at Los Angeles Mission College – www.lamission.edu - **[Apply Online]**

☐ Passed all Health Occupation courses with a grade of "C" or better (STRONGLY RECOMMENDED)

☐ *(2 copies)* **Cardiopulmonary Resuscitation (CPR) – American Heart Association *(AHA)* Basic Life Support *(BLS)* for Health Care Providers** certification valid through the duration of the program. ***(Available at LAMC as Allied Health 021).***

☐ **Health Record** *(pages 6-7)* must be completed *prior to the start of the program* and signed by a Physician, Nurse Practitioner, or Physician Assistant, specifying that you can participate in the classroom and clinical internship portions of the program without any limitations. Health Record must include the following *(provide **2 copies of each** documentation listed)*:

☐ **Free of Communicable Diseases** | ☐ **Approved & Recommended for Nursing Program**

- ☐ **Physical Examination** - *must be completed within **90 days** prior to the start of the program*
- ☐ **Proof of Absence of Tuberculosis** - *negative skin test (within **60 days** prior to the start of program)*
  -OR- negative chest x-ray (within 2 years prior to the start of program)
- ☐ **Immunization Record or Titer Test Result of:**
  - ☐ ***Hepatitis B*** ☐ ***MMR:*** ☐ ***Measles,*** ☐ ***Mumps,*** ☐ ***Rubella***
  - ☐ ***Polio*** ☐ ***Tetanus*** *(within 10 years)* ☐ ***Varicella*** *(Chicken pox)*
- ☐ **Urine Negative Drug Test** *(8 panels, within **90 days** prior to the start of program) – Lab Results must be included*
- ☐ **Flu Vaccination** STRONGLY RECOMMENDED. *If flu vaccination is not obtained, student must submit Declination Form and wear a mask during clinical portion of the training.*

☐ *(2 copies)* **Malpractice "Certificate of Insurance" documentation** (District requires $1,000,000 single occurrence & $3,000,000 Aggregate) – *See pages 2 and 3.*

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Student file reviewed by: _____ Date: _____

If complete, provide:

- ☐ Live Scan / Criminal Background Clearance: ☐1 *original*
- ☐ CDPH 283B / CNA Initial Application Form: ☐1 *original*; ☐3 *copies*
- ☐ CDPH 283D / HHA Initial Application Form: ☐1 *original*; ☐1 *copy*
- ☐ Evidence of Understanding from Student Handbook: ☐1 *original*; ☐1 *copy*

Student approved for entrance into the program by: _____ Date: _____

LOS ANGELES MISSION COLLEGE

Nurse Assistant & Home Health Aide Training Programs Admissions Application

Give careful consideration to each question on this form. This form must be completed in its entirety for consideration by the committee. Eligible students will be admitted based on first come, first served.

STUDENT ID#: _____ SOCIAL SECURITY NUMBER: _____

1. NAME _____ _____ _____
   LAST FIRST MIDDLE

2. PERMANENT ADDRESS _____
   NUMBER & STREET CITY STATE ZIP

3. EVENING PHONE _____ DAYTIME PHONE _____

4. E-MAIL ADDRESS _____

5. BIRTHDATE _____ AGE _____

6. OTHER THAN ENGLISH, WHAT LANGUAGE(S) ARE YOU PROFICIENT IN? *(Circle all that apply/specify.)*

♦ American Sign Language	♦ Arabic	♦ Chinese; including its various dialects (*specify* _____)			
♦ Farsi	♦ French	♦ Japanese	♦ Russian	♦ Spanish	♦ Tagalog
♦ Other, please specify: _____			♦ Not applicable (English-only)		

7. DO YOU HAVE A HIGH SCHOOL DIPLOMA OR GED? **Y_____ N_____ WHAT YEAR?** _____

8. DO YOU HAVE A BASIC LIFE SUPPORT CPR CARD? Expiration date_____ *(If not, you can enroll in the **Allied Health 21** course.)*

9. **EXAMINATIONS/VACCINATIONS:** *Required before the start of the program. Immunization paperwork will be provided before the start of the program*

1. COMPLETE PHYSICAL EXAMINATION	4. HEP B: *Proof of Vaccination or Titer Result*
2. TB SCREENING	5. MMR: *Proof of Vaccination or Titer Result*
3. TETANUS: *Proof of Vaccination within 10 years*	6. Varicella (chicken pox): *Proof of Vaccination or Titer Result*

10. **REQUIRED ITEMS:**

	✓ Textbooks *(1 of each)*:	
✓ Watch with second hand ✓ Uniform- scrubs	(1) ***CNA: Nursing Assistant Certification, California Edition*** Author: Carrie L. Jarosinski © August Learning Solutions ISBN-13: 9781941626030	(2) ***CNA: Nursing Assistant Certification, California Edition Workbook*** Author: Lisa Rae Whitley © August Learning Solutions ISBN-13: 9781941626160

Students successfully completing the Nurse Assistant course will be eligible for certification through the State of California Department of Public Health. To participate in the clinical portion of the program the applicant will need to be fingerprinted and have a criminal background check completed. This is also required for certification. Applicants who have been convicted of a criminal offense may not be eligible for certification. Please visit the certification requirements online: *https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/CNA.aspx* & *https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/HHA.aspx*.

By signing this form you are verifying that you understand the prerequisites and the licensing requirements for the Nurse Assistant and Home Health Aide Training Programs. I understand that falsification or intent to withhold information under penalty of perjury shall constitute grounds for dismissal.

_____ _____
SIGNATURE DATE

LAST NAME	FIRST NAME	MIDDLE INITIAL	MARITAL SATUS SINGLE DIVORCED MARRIED NO CHILDREN	HEALTH **RECORD**
ADDRESS *(STREET, CITY, ZIP)*				
TELEPHONE	**WHAT ARE YOU STUDYING TO BE?** *(SELECT ALL THAT APPLY)* ☐ Certified Nurse Assistant ☐ Home Health Aide			
NAME AND ADDRESS OF FAMILY DOCTOR/CLINIC			**STUDENT ID NUMBER**	
DATE OF BIRTH	**LAST HIGH SCHOOL ATTENDED** *(NAME, CITY, STATE)*			

UNDERLINE DISEASE(S) YOU HAVE HAD

ANEMIA
ASTHMA
APPENDICITIS
BLACKOUTS
BRONCHITIS
CHICKEN POX
DIABETES
DIPTHERIA
EPILEPSY
HAY FEVER
EAR PROBLEM
HEART TROUBLE
JAUNDICE
KIDNEY PROBLEM
LARYNGITIS
MUMPS
MEASLES
NERVOUS BREAKDOWN
PLEURISY
PNEUMONIA
POLIO
RHEUMATIC
RHEUMATIC FEVER
SCARLET FEVER
SMALL POX
SICKLE CELL
SINUSITIS
TONSILITIS
TYPHOID FEVER
THYROID DISORDER
TUBERCULOSIS
ULCER
VARICOSE VEINS
WHOOPING COUGH

FAMILY HISTORY *(UNDERLINE and NOTE RELATIVE)*

TUBERCULOSIS
NERVOUS BREAKDOWN
DIABETES
CANCER

WHAT VACCINATIONS OR TESTS HAVE YOU HAD? WHAT YEARS?

☐ SMALL POX_____ ☐ TETANUS_____ ☐ CHEST X-RAY_____ ☐ POLIO_____

SERIOUS ILLNESSES:

_____

_____

OPERATIONS:

_____

_____

LIST YOUR MAJOR INJURIES:

_____

_____

ALLERGIES:

_____

_____

A complete physical examination including labs is required every two (2) years unless otherwise specified by affiliating hospital contracts.

PHYSICAL EXAM: **DATE:** _____			ADDITIONAL DATA – SUMMARY - RECOMMENDATIONS
GENERAL APPEARANCE:	HEIGHT	WEIGHT	
POSTURE			
SKIN:	BACK:		
EYES: PERLA:	RETINA:		
EARS: R L	HEARING:		
NOSE AND THROAT:			
TEETH: GUMS: DENTAL HYGIENE			☐ **FREE OF COMMUNICABLE DISEASES – DOES NOT CREATE HAZARD TO SELF OR OTHERS**
GLANDS: THYROID			☐ **APPROVED AND RECOMMENDED FOR NURSING PROGRAM**
LUNGS:			☐ NOT APPROVED – SEE ABOVE
HEART:			☐ APPROVED PENDING AS ABOVE
PULSE:			**EXAMINED BY:** , MD
ABDOMEN:			NURSE PRACTITIONER
ENDOCRINE SYSTEM:			**LICENSE NO:**

NERVOUS SYSTEM:	**ADDRESS & PHONE NO.**
BLOOD PRESSURE:	

STUDENT'S NAME (Print) _____ **Student ID #:** _____

*(*Required for NA Program)*	Date*(s)*	Results	Dr. Signature/Address/Phone Number
***Tuberculin Skin Test** OR **Chest X-ray**			
***Hepatitis B** *(Titer/Vaccine)*			
***Measles** *(Titer/Vaccine)*			
***Mumps** *(Titer/Vaccine)*			
***Rubella** *(Titer/Vaccine)*			
***Polio** *(Titer/Vaccine)*			
***Varicella (Chicken Pox)** *(Titer/Vaccine)*			

***Diphtheria/Tetanus** *(Series of two, one month apart. Boosters in one year, then repeat in ten years. If you had series as a child, then all you need is the booster).* _____ _____ _____ _____

***Drug Screen** _____ _____ _____
(8-panel minimum, with Lab Results)

***Flu Vaccine** *(or Declination Form)* _____ _____ _____

IF THE TITER IS NEGATIVE, A VACCINE WILL BE REQUIRED. THEN A REPEAT TITER AS DESIGNATED PER MEDICAL PROTOCOL.
COPIES OF ALL LABORATORY REPORTS ARE REQUIRED.

2019-2020 INFLUENZA VACCINATION WRITTEN DECLINATION FORM
(Los Angeles Mission College Nurse Assistant Training Program)

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the 2019-2020 season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

I **decline vaccination** for the following reason(s). Please check all that apply.

☐ I believe I will get influenza if I get the vaccine.

☐ I do not like needles.

☐ My philosophical or religious beliefs prohibit vaccination.

☐ I have an allergy or medical contraindication to receiving the vaccine.

☐ I do not wish to say why I decline.

☐ Other reason – please tell us. _____

Print Name _____ Department _____

Signature _____ Date _____

Allied Health 21 Course – CPR Card Fee Form

(Complete and take this form to LAMC Business Office.)
If the form is incomplete, the Business Office will not accept it.

Student Name: _____

Student ID#: _____

Section # & Semester & Year: _____

Instructor: Professor Pullukalayil

Cost of the CPR card: $15.00

Total Amount Paid: _____

BUSINESS OFFICE, *please* STAMP HERE

Student, you must keep this half-sheet for your records.

---------- *Do not write below this line. For Business Office Use Only.* ----------

Student Name: _____

Student ID#: _____

Section # & Semester & Year: _____

Instructor: Professor Pullukalayil

Cost of the CPR card: $15.00

Total Amount Paid: _____

LOS ANGELES MISSION COLLEGE

NURSE ASSISTANT & HOME HEALTH AIDE TRAINING PROGRAM

Reimbursement / Tuition Assistance Application

In accordance to the Arthur Rupe Foundation grant agreement with Los Angeles Mission College, you may be eligible to receive reimbursement up to $245 toward your drug testing, malpractice insurance, certification exam, and CPR card fees after you successfully complete the California Department of Public Health (CDPH) examination *(subject to verification; receipts are required)*

Please fill out completely:

Name: _____ Student ID: _____

Email: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____

Semester *(select one)*: ☐ Fall ☐ Spring ☐ Summer Year: __ __ __ __

☐ Passed CDPH Exam Certificate/License on: _____
Date

Required Documents *(please keep a copy for your file and attach **original** receipts for)*:

☐ Drug Test
☐ Malpractice Insurance
☐ CPR Fees
☐ Scrubs with LAMC Logo purchased from LAMC Eagles' Landing Student Store
☐ Nurse Assistant Name Tag Holder purchased from LAMC Eagles' Landing Student Store
☐ CDPH Exam Certificate/License

Student Signature: _____ Date: _____

----------***OFFICE USE ONLY***----------

Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Comments: _____

_____

Award Amount: _____