



Certified Nurse Aide Training Program

Mandatory Requirements

- Registration Form
- Application for Training
- Reading & Math Assessment
- Criminal Background Check
- Fingerprinting
- 2 Step PPD Test
- Physical Exam
- Covid-19 Vaccination and Booster (if applicable)
- Online HIPPA Course
cf.rcgc.edu/hipaa/assessment

I understand that all the above documentation must be submitted to the Career & Technical Education Division for enrollment into the Certified Nursing Assistant Training Program.

Student Name: _____

Student Signature: _____

Date: _____

RCSJ CTE Representative: _____

Signature: _____

Date: _____



CTE Registration Form

Please complete all sections

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Birth Date: _____ Social Security #: _____

How did you hear about our programs?

- CTE Catalog Opportunity Magazine RCSJ Website Social Media
- Friend/Relative Newspaper Ad Other

Course#	Course Title	Dates	Cost
Total:			

Please Note: With the submission of this form, you are registered for the course. Unless notified to the contrary, please report to your first scheduled class. **If your program course is being funded through a grant and you do not complete the program, you will be liable for the entire cost of the program; Courses costing more than \$500 require a 50% deposit to hold your seat.**

Refund/Withdrawal Policy: We are happy to offer a refund or apply payment to another class of your choice if you withdraw five business days prior to the start of a class. Balance due by first day of class. If you wish to withdraw from a course, please notify the Career and Technical Department in writing or in person immediately. Refunds will be made as follows:

- 100% refund prior to the first class meeting.**
- 50% refund on first day of class.**
- No refund after the first day.**

By signing here, I understand and agree to the above terms and conditions: _____

Mail Registration Form To:

Rowan College of South Jersey—Cumberland
Career and Technical Education
3322 College Drive
Vineland, NJ 08360

Rowan College of South Jersey—Gloucester
Career and Technical Education
1400 Tanyard Road
Sewell, NJ 08080v



CTE Allied Health Program Application

Section 1: Student Information

Full Name: _____ Maiden/Other Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____ SS#: _____

Phone: _____ Birth Date: _____

Do you have a High School Diploma or GED? Yes (Please attach copy) No

Section 2: Program Selection and Status

I am applying for admission to:

Section 3: Immunizations and Tests

Program:	Check	Dates
Certified Clinical Medical Assistant		
Certified Nursing Assistant		
Patient Care Technician		
Certified Phlebotomy Technician		
Medical Billing & Coding		
Pharmacy Technician		
Central Service Technician		
Medical Administrative Assistant		
Other:		

Only for: Certified Clinical Medical Assistant, Certified Patient Care Technician, Phlebotomy Technician, Certified Central Service Technician and Pharmacy Technician. Please attach a copy of your physical and immunizations as necessary.

Vaccine	Dose-Date
Hepatitis B	1.
	2.
	3.
PPD Test Results (mm)	Date*:
MMR vaccination/Titer	Date:
Varicella vaccination/Titer	Date:
Flu Vaccine	Date: Verification Required

*Tuberculin test cannot be older than one year.

C.N.A Immunizations and Tests – **See C.N.A Requirements Packet**

Continues on next page

Physician's Signature & Date: _____



Section 4: Acknowledgments

Externship (Only for Certified Clinical Medical Assistant, Certified Phlebotomy Technician, Certified Patient Care Technician and Central Service Technician – Initial after each.):

- **I understand** that if my program requires an externship, I will be required to complete all required hours before I will be considered a “graduate” of the program. _____
- **I understand** that my externship site could be within up to 30 miles of the school. _____
- **I understand** that most externship sites only offer externship during weekday hours and may not have the availability to provide evening or weekend hours. _____
- **I understand** that if I decline an externship site, the college’s obligation regarding externship has been met and I will have to find my own externship placement. _____
- **I understand** that if I am dismissed from an externship site, I will meet with the Director of Career and Technical Education and must find my own externship placement. _____
- **I understand** that if I don’t have a minimum of a “C” average or an 85% attendance record that I may not be eligible for externship placement. _____
- If I am not in good financial standing with the College, I will not be able to be placed on externship until paid in full. _____
- **I understand** that I will need to submit proof of being fully vaccinated against COVID-19 in compliance with externship site requirements. _____

Certification Exams and Licensures (Initial after each):

- **I understand** that Rowan College of South Jersey makes no guarantee that students who complete training will pass the national certification exam and licensures (*if available*). _____
- **I understand** that Rowan College of South Jersey will only pay for my first attempt at the national certification exam and licensure. All retests are my responsibility. _____

Release of information

I, (print name) _____, authorize Rowan College of South Jersey Career and Technical Education to conduct a search and to release all my records pertaining to my criminal history, which includes my name, social security number, date of birth, address, and student ID number to the authorized background check agency of their choice.

I understand that the use of my records is limited to any audit and the evaluation of continuing education programs, to any potential externship preceptors, and in connection with the enforcement of federal and/or-state laws.

My signature is an acknowledgment that I have read and voluntarily consent to the release of the above-mentioned information.

Student Signature: _____

Refund Policy

There will be a 100% refund for withdrawals before the first day of class. A 50% refund for withdrawals on the first day of class. No refunds after the first day of class.

I understand and agree to the above terms and conditions:

Student Signature: _____ Date: _____



CTE Acceptance of terms of Drug and Alcohol Use Policy

It is strictly forbidden to be under the influence of alcohol, illegal narcotics, chemicals, psychedelic drugs or other controlled substances by an individual engaged in college related activities.

It is expected that students will come to class, laboratory and externship in a condition fit for the competent and safe performance of their duties and that such fit condition will be maintained throughout the scheduled time. The objectives of this policy are to identify the impaired students, maintain an environment that allows students to enjoy the full benefits of their learning experience and ensure safe, competent client care.

Faculty are accountable for ensuring that students are in fit condition to participate in program related activities and for taking prompt, appropriate and decisive action whenever a student seems to be impaired. Students who arrive in the classroom, lab, externship location or other assigned area and are considered by their instructor to be impaired may expect to:

- Have their behavior witnessed and documented
- Be questioned in private as to the nature of their problem
- Be asked to undergo a medical evaluation (which includes blood alcohol level and/or urine testing) in an Emergency Room or laboratory facility and have their behavior witnessed by another healthcare professional
- Meet with the Director of Career and Technical Education
- Be referred for counseling
- Be dismissed from their program of study
- Be ineligible for readmission

When a student is in possession of or using alcoholic beverages or illegal or unprescribed controlled chemicals on college or externship properties, the student may be assigned a grade of "F" and be dismissed from their academic program. I have read and understand the Career and Technical Education's Drug and Alcohol Use Policy.

Signature:

Date:



By Morpho Trust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/ni

(1) Originating Agency Number (ORI #) NJ920580Z		(2) Category HCK	(3) Statute Number N.J.S.A. 26:2H-83		
(4) Reason for Fingerprinting CERTIFIED NURSE AIDE/CARE GIVER			(5) Document Type RB2	(6) Payment Information NJDOH PAYS COSTS	
(7) Contributor's Case # (Unique Identifier) CNA			(8) Miscellaneous		
(9) First Name		(10) MI	(11) Last Name		
(12) Daytime Phone Number ()		(13) Social Security Number*		(14) Date of Birth	(15) Height
(16) Weight		(17) Maiden or Alias Last Name		(18) Place of Birth (US State if US Citizen; Country for all others)	
(19) Country of Citizenship					
(20) Home Address Address City State Zip					
(21) Gender (Select one) <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both		(22) Hair Color	(23) Eye Color	(24) Race (Select One) [A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian/ Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown	
(25) Occupation / Position (with respect to Requirement)		(26) Employer/ Organization Name (with respect to Requirement) Employer Address City State Zip			
Identification Requirement: Acceptable Identification must be presented at the time of printing. Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria: Photo, Name, Address (home/employer), Date of Birth. Acceptable ID must be issued by a Federal, State, County or Municipal entity for identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).					

Please READ This Form Carefully:

Follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. **PLEASE PRINT LEGIBLY.** It is **required** that you **present** this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.

Appointment Scheduling:

Scheduling is available anytime at www.bioapplicant.com/ni. Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an applicant is responsible for payment, payment is required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, prepaid debit cards, or electronic debit (ACH) from a checking account. Accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center **before the deadline of 5PM EST** the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of \$10.00 plus tax (\$10.70) will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment, inability to present proper identification, inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2, or the information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a \$10.00 plus tax (\$10.70) appointment fee. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information:		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

IDG_NJAPP_020115_V2

**New Jersey Department of Health
Criminal Investigation Unit
P.O. Box359
Trenton, NJ 08625-0359**

**TO: All New Applicants for Certification as a Nurse Aide
All Reciprocity Candidates for Nurse Aide Certification**

SUBJECT: Fingerprint Process

New Jersey law requires that every candidate for certification as a nurse aide must submit to a fingerprint process before the Department can grant certification (, J.S.A. 26:2H-83, et seq.). You must provide fingerprint impressions that will be used to check the criminal history records of the New Jersey State Police and the Federal Bureau of Investigation (FBI) to determine if you have been convicted of a disqualifying offense. Also, we will be notified if you are convicted of an offense at a later date.

In order to have your fingerprints taken, you must make an appointment with the vendor designated by the New Jersey State Police to take fingerprint impressions. The vendor, Morpho Trust, will take information from you, including the codes on the reverse side of this letter. You will be scheduled to report to a local site and have your fingerprint impressions taken. On the day you report, you **MUST BRING A PHOTO ID ISSUED BY A GOVERNMENTAL AGENCY {see the list of approved identification documents on reverse side} AND TIDS FORM.** Failure to follow this direction will result in your being turned away at the center and will require you to make a second trip. To arrange to have your fingerprints taken, visit the website www.bioapplicant.com/nj at any time. If you do not have access to the Internet, call Morpho Trust toll-free at **(877) 503-5981**** during regular business hours. Please note that during certain times of the year waiting times for the call center can exceed 10 minutes. Either way you make your appointment, you must provide them with the information listed on the reverse side of this letter.

You are required to keep any appointment you make with the vendor. If you cannot keep your appointment, you must call the vendor by 5 PM the business day before your appointment to cancel and reschedule. Failure to keep your fingerprint appointment may result in your disqualification from certification as a nurse aide in New Jersey. The vendor reports all "no-show" applicants to the Department.

You are not required to pay for these services. The Department of Health will pay for your fingerprints and the scanning service. You do not have to give the vendor any money at the time you are fingerprinted. Once you are fingerprinted, the vendor will give you a special number, called a **PCN**. You should write this number down on this form and keep it for your records. This proves that you have had the fingerprints completed and can help us track down information or to re-send your fingerprints in the future.

REMEMBER: You MUST still complete a notarized "Criminal Background Investigation Application" and mail it to the Department. Failure to complete the application can result in denial of certification or a delay in processing your results.

***Privacy Act Notice (PL 93-579)** The submission of social-security numbers are mandatory for nurse aides pursuant to 42 USC 666 and N.J.S.A. 2A:17-56.44(e), and are used to uniquely identify candidates for nurse aide certification and to comply with child support order enforcement pursuant to N.J.S.A. 2A:17-56.41, et seq.

****** Hearing and sight impaired candidates may call the NJ Relay Service at 711 or (800) 852-7899.



Physical Examination Form for Certified Nurse Aide

To be completed by a Health Care Provider

Instructions: This Physical Examination Form is to verify the health status of this student who has been accepted into the Central Service Technician program at Rowan College of South Jersey upon verification of adequate health status.

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ E-mail Address: _____

Home Phone: _____ Cell Phone: _____

Date of Exam: _____

HT: _____ WT: _____ BP: _____ P: _____ Urine Dip: _____ Hb: _____

- | | |
|--------------------------|--|
| NL | ABNL Findings |
| <input type="checkbox"/> | <input type="checkbox"/> Head/Neck _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Eyes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> ENT _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Lungs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Cardiac _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Breast _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Abdomen _____ |
| <input type="checkbox"/> | <input type="checkbox"/> GU (as indicated) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Rectal (as indicated) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Back Strength/Extremities _____ |

- | | |
|--------------------------|--|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Ability to lift and carry up to 50 lbs. _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Ability to exert up to 100 lb. Force or push/pull _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Ability to bend/stand/squat/crawl _____ |

- | | |
|--------------------------|---|
| NL | ABNL |
| <input type="checkbox"/> | <input type="checkbox"/> Neuro _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Reflexes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Lymph's _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Skin _____ |

Remarks: _____

The student is sufficiently free of disease and able to perform duties. He/she does not have any health condition that would create hazard for him/herself, fellow students, facility employees, residents, or visitors.

MD signature: _____ Date: _____

Tuberculin Skin Test Requirements	Date/Results	Date/Results
2 Step TB Skin Test (PPD) 2 TB Skin Test: a minimum of 1 week or a max of 3 weeks apart	1 st Step Date: _____ Results: _____ * If positive PPD result, see Chest Xray & Letter	2 nd Step Date: _____ Results: _____
Chest Xray & Letter from Physician * Only require if positive TB Skin Test * Negative Chest Xray (within last 5 years) * A letter from your physician stating you are free of any symptoms of TB	Date: _____ Results: _____ INH Treatment- 9 Mos. Date Began: _____ Date Ended: _____	

TB Symptoms Review:

1. Are you currently exhibiting any of the following symptoms of tuberculosis?

- | | | | | |
|--|-------|-----|-------|----|
| Hoarseness/Cough lasting longer than 3 weeks | _____ | yes | _____ | no |
| Coughing up Blood | _____ | yes | _____ | no |
| Fever | _____ | yes | _____ | no |
| Weight Loss | _____ | yes | _____ | no |
| Night Sweats | _____ | yes | _____ | no |
| Excessive Fatigue | _____ | yes | _____ | no |

Have you had any of the above TB symptoms within the last 12 months? _____

If yes, explain _____

2. Have you ever been told by a doctor or other health care provider that you had active TB? _____ Yes or No

3. Have you ever been told by a doctor or health care provider that your immune system is not working right or that you cannot fight infection? _____ Yes or No

4. Have you had pneumonia in the past year? _____ Yes or No

5. Have you ever lived with or had close contact with someone who has/had active TB with symptoms listed above? _____ Yes or No.

If yes, list symptoms _____

6. Is any person living in your household exhibiting any symptoms of TB that are listed above? _____ Yes or No

If yes, list symptoms _____

7. Have you ever been told that you have an abnormal chest x-ray or had a chest x-ray to rule out TB? If yes, where was the chest x-ray done; physician name and number: _____



8. Have you ever received medication for active tuberculosis disease or preventative treatment for TB injections?

If yes, list medication, date started, and date completed: _____

9. Have you ever worked where patients with active tuberculosis are receiving care? _____

10. Have you ever worked, volunteered, or lived in any situation such as jail, group home, or homeless shelter? _____

11. Have you ever traveled outside the United States? _____ If yes, where _____

12. Were you born in the United States? _____ If no, where were you born? _____

Student signature: _____ Date: _____