Career & Technical Education
Rowan College of South Jersey

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)

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: _____

Career & Technical Education
Rowan College of South Jersey

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

Career & Technical Education
Rowan College of South Jersey

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

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:		

CAREER & TECHNICAL EDUCATION
Rowan College of South Jersey

Section 4: Acknowledgments

Externship (Only for Certified Clinical Medical Assistant, Certified Phlebotomy Technician, Certified Patient Care Technician, Certified Nursing Assistant 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 withwin 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: _____

CAREER & TECHNICAL EDUCATION
Rowan College of South Jersey

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:*

IdentoGO
By Morpho Trust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/ni

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number
NJ920580Z	HCK	N.J.S.A. 26:2H-83

(4) Reason for Fingerprinting	(5) Docur entType	(6) Payment Information
CERTIFIED NURSE AIDE/CARE GIVER	RB2	NJDOH PAYS COSTS

(7) Contributor's Case # (Unique Identifier)	(8) Miscellaneous
CNA	

(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)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [ ] 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 10/31/201O).

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 LEG/BLY**. 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/nj.** 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

New Jersey Department of Health
Criminal Investigation Unit
PO BOX 359
Trenton, NJ 08625-0359

☐ CNA/PCA
☐ CALA

CRIMINAL BACKGROUND INVESTIGATION APPLICATION

Please make sure you have both this application and the instructions so that the completed application is accurate. Remember, you must make and complete a fingerprint appointment before you can obtain certification. Please refer to the instructions on the fingerprint form for information on how to make a fingerprint appointment.

COMPLETE THE FOLLOWING INFORMATION, SIGN, AND DATE THE APPLICATION

Last Name		Suffix
First Name	Middle Name	
Social Security Number		Gender
Street Address		Apt. No.
City	State	Zip Code
Telephone No.	Date of Birth	
Training Program Facility Name		Facility ID
Facility Address		

SCREENING QUESTIONS FOR ALL APPLICANTS

Screening questions must be completed by all applicants. REMINDER: Failure to provide documentation for any questions answered "YES" will prevent completion of the certification process.

1.	Have you ***ever*** been found guilty of a criminal or administrative charge of resident abuse and/or neglect, or misappropriation or theft of a resident's property, or have you ***ever*** been placed on a state or other jurisdiction's abuser registry?	☐ Yes ☐ No
2.	Have you ***ever*** been convicted of any of the offenses or crimes listed on the back side of this application? Conviction includes a finding of guilt by trial judge or jury, a plea of guilty and/or a plea of no contest.	☐ Yes ☐ No

SIGNATURE AND NOTARIZATION

State of	County of

I hereby certify that I have answered the questions on this application truthfully and honestly. I understand that any false answer on this application form shall result in my **immediate** disqualification from certification as a Nurse Aide/Personal Care Assistant or Assisted Living Administrator in New Jersey for at least two (2) years and may subject me **to a fine of up to $1,000**. I hereby release any and all records of arrests and/or convictions to the New Jersey Department of Health, and consent to an investigation into any arrest, conviction or allegation of abuse or neglect. I understand that my fingerprints will be used to check the criminal history records of the New Jersey State Police and the Federal Bureau of Investigation. I understand that, if certified, subsequent conviction of any offense listed on the reverse side of this application shall result in the disqualification from certification. I understand that as a condition of certification, any arrests or convictions that occur will be reported to the Department of Health. I certify that I have read and understand this application and the New Jersey Nurse Aide/Personal Care Assistant Candidate Information Bulletin.

Signature of Applicant	Date of Signature

Subscribed and sworn to before me, this _____ day of _____, 20_____

Signature of Notary Public	My Commission Expires

SEAL

CRIMINAL BACKGROUND INVESTIGATION APPLICATION CONTINUED

New Jersey State law provides that a person shall be disqualified from certification if that person's criminal history record background check reveals a record for conviction of any of the following crimes or offenses (including those committed in another state or jurisdiction), unless that person has obtained a determination of rehabilitation from the New Jersey Commissioner of Health (N.J.S.A. 26:2H-83):

Chapter 11: Murder, Criminal Homicide, Manslaughter, Death by Auto, Leaving the Scene of an Accident with the Death of a Person(s), Aiding Suicide.

Chapter 12: Aggravated Assault, Simple Assault, Assault, Battery, Leaving the Scene of an Accident with Serious Injury to Another, Terroristic Threats, Reckless Endangerment, Stalking, Disarming Police/Corrections, Threats Against Health Care Professional, Volunteer, Throwing Bodily Fluids on Corrections and other offenses that may be referred to as Offensive Touching, Assault, Abuse (Spousal or other), Domestic Violence or Battery or other similar terms for out-of-state convictions.

Chapter 13: Kidnapping, Criminal Restraint, False Imprisonment, Interfering with Custody, Criminal Coercion, Enticing a Child into a Vehicle or Structure.

Chapter 14: Aggravated Sexual Assault, Rape, Sexual Assault, Criminal Sexual Assault, Lewdness, any sexual offense other than simple prostitution, any offense requiring registration under Megan's Law.

Chapter 15: Robbery, Carjacking.

Chapter 20: Larceny, Grand Larceny, Petit or Petty Larceny, Possession of Stolen Property, Theft by Unlawful Taking, Theft by Deception, Extortion, or Failure to Make Required Disposition, Receiving Stolen Property, Fencing, Theft of Services, Shoplifting, Theft of Library Materials, Computer Related Theft, Car Theft, Theft, Fraud, Maintaining "Chop Shop," Using Juveniles in Auto Theft, Retail Theft.

Chapter 24: Endangering the Welfare of Children, Elderly, or Incompetent Persons, Endangering Another Person, Bigamy, Willful Non-Support, Unlawful Adoptions, Child or Elder Abuse (some jurisdictions), Child Abuse (in some jurisdictions), any offense requiring registration under Megan's Law (N.J.S.A. 2C:7-1 et seq.).

Chapter 35: Possession, Use or Distribution of Controlled Dangerous Substances or Analogs, or Related Offenses. Does not include convictions of Possession of Marijuana 50 Grams or Less, or Possession of Hashish 5 Grams or Less [Specifically (N.J.S.A. 2C:35-10(a)4)].

A conviction includes any conviction for an attempt or conspiracy of any of the above charges. Also, any conviction which impacts on the ability of the candidate to provide services as a Nurse Aide/Personal Care Assistant may be the basis for disqualification pursuant to N.J.S.A. 26:2H-83 or as an Assistant Living Administrator pursuant to N.J.S.A. 26:2H-7.17. NOTE: Out-of-State convictions may use terms that differ from those used in New Jersey. However, if the ACT would result in a disqualifying conviction if committed in New Jersey, you ***MUST*** disclose it by answering "Yes" to question #2 on the reverse side of this form or you will be disqualified from certification in New Jersey for at least two (2) years.

Please Note: Criminal history information is PERMANENT unless expunged or sealed by judicial order. Criminal history information does not "go away" or "disappear" after seven years, etc. **BE SURE TO ANSWER "YES" IF YOU HAVE *EVER* BEEN CONVICTED OF ANY OF THESE CRIMES OR OFFENSES, OR YOU WILL BE DISQUALIFIED FROM CERTIFICATION FOR AT LEAST TWO (2) YEARS.**

If you need assistance with this application, you may call the Criminal Investigation Unit at 1-609-292-4303 (out-of-state, call 1-866-561-5914).

All criminal background investigation materials should be returned to:

Criminal Investigation Unit
PO Box 359
Trenton, NJ 08625-0359

YOU MUST MAIL THIS ORIGINAL APPLICATION TO THE CRIMINAL INVESTIGATION UNIT.

Please be sure to retain copies of any document you submit. You must allow at least 12 weeks for processing.

CRIMINAL BACKGROUND INVESTIGATION APPLICATION INSTRUCTIONS

THESE INSTRUCTIONS MUST BE FOLLOWED EXACTLY.

Please review the instructions carefully before completing the application. Take time completing the application and **PRINT ALL INFORMATION LEGIBLY IN BLACK INK**. If the application is NOT properly completed, it will be returned to you without being processed. You will need to make the required corrections and re-submit the application. THIS WILL DELAY THE PROCESS FOR OBTAINING YOUR CERTIFICATION.

APPLICATION TYPE ***(located on upper right corner of the application)***

- Certified Nurse Aide or Personal Care Assistant candidates: check the CNA/PCA box.
- Certified Assisted Living Administrator candidates: check the CALA box.

NAME, DATE OF BIRTH, SOCIAL SECURITY NUMBER*, TELEPHONE NUMBER, ADDRESS, AND LONG-TERM CARE EMPLOYER OR TRAINING PROGRAM

Complete the fields for Name, Date of Birth, Social Security Number*, Telephone Number, Address, and Long-Term Care Employer or Training Program.

*Privacy Act NOTICE (PL 93-579): Submission of your Social Security Number is mandatory for certified nurse aides, personal care assistants, and certified assisted living administrators pursuant to N.J.S.A. 2A:17-56.44(e), as authorized by 42 U.S.C. 666, and are used to uniquely identify candidates for certification, coordinate criminal history information with the required criminal history registries, and to comply with child support enforcement laws.

SCREENING QUESTIONS FOR ALL APPLICANTS

1. Answer BOTH screening questions.

2. If you answer YES to either or both questions, you must provide the items listed on the reverse side of these instructions with this application. NOTE: Answering YES does NOT necessarily prevent an individual from obtaining certification. However, answering NO, if the person has been convicted of disqualifying offenses, will result in disqualification from certification for at least two (2) years.

3. State law allows a person who has not been convicted of a disqualifying offense to work as a Nurse Aide, Personal Care Assistant, or Assisted Living Administrator for up to 120 days while the criminal history background check is being conducted. If you have answered NO to both questions, please provide a copy of the application to your employer as proof of this eligibility.

4. The completed application MUST be notarized, or it will be returned. Remember, this application is a sworn affidavit. False statements are punishable by law. Please send all material to:

Criminal Investigation Unit
PO Box 359
Trenton, NJ 08625-0359

YOU MUST MAIL THE ORIGINAL APPLICATION TO THE CRIMINAL INVESTIGATION UNIT.

Please be sure to retain copies of any document you submit. You must allow at least 12 weeks for processing.

If you have convictions for any of the offenses listed on this application, please read “How to Request a Determination of Rehabilitation” on the reverse side of these instructions.

HOW TO REQUEST A DETERMINATION OF REHABILITATION

If you have been convicted of an offense which would disqualify you from certification as a Certified Nurse Aide, Personal Care Assistant, or a Certified Assisted Living Administrator, you may request the Department of Health review all pertinent facts regarding the conviction(s). **However, if you have ever been convicted of the following offenses you cannot request a determination of rehabilitation and you are permanently disqualified from certification: N.J.S.A. 45:1-15.9, specifically, sexual assault, criminal sexual contact or lewdness pursuant to N.J.S. 2C:14-2, N.J.S. 2C:14-3, and N.J.S. 2C:14-4 that is of the first, second, third or fourth degree, endangering the welfare of a child pursuant to paragraph (1) of subsection a. of N.J.S. 2C:24-4, attempting to lure or entice a child pursuant to section 1 of P.L. 1993, c.291 (2C:13-6), or equivalent offenses in another jurisdiction.** If you have not been convicted of the above bolded offenses the law states that the Department of Health must consider:

- The nature and responsibility of the position which you will hold, or have held;
- The nature and seriousness of the offense(s);
- The circumstances under which the offense(s) occurred;
- The date of the offense(s);
- Your age at the time you committed the offense(s);
- Whether the offense(s) was/were an isolated event or a repeated incident;
- Any social condition which may have contributed to the offense(s); and
- Any other evidence of rehabilitation, including good conduct in prison or the community, counseling or psychiatric treatment, academic or vocational schooling, successful participation in work-release programs, or the recommendation of those who have had you under their supervision.

You MUST submit the following:

- A personal statement from you which gives the details of the offense, including personal and social circumstances which existed at that time *(you must provide as much information as possible)*;
- If you believe that a conviction was reported in error, a certified copy of the Judgment of Conviction or other document issued by the court in which you were convicted of the offense(s);
- A report from your probation or parole office indicating that you are in compliance with the conditions of your release and/or have been discharged from probation or parole (if applicable);
- Proof of drug counseling and/or treatment *(if your offense(s) were drug related)*; and
- A statement of support from your Nurse Aide Training and Competency Evaluation Program Instructor, or your employer.

The following are NOT required, but you may also submit:

- Personal reference letters, including letters of support from counselors, correction personnel or clergy;
- Certificates of training and schooling (for example, vocational training, other certifications and/or licenses, and GEDs); and
- Any other documents which help demonstrate that you can work safely with the infirm or elderly.

Please submit the required information to:

Criminal Investigation Unit
PO Box 359
Trenton, NJ 08625-0359

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: _____ Hb: _____

NL	ABNL Findings
☐	☐ Head/Neck _____
☐	☐ Eyes _____
☐	☐ ENT _____
☐	☐ Lungs _____
☐	☐ Cardiac _____
☐	☐ Breast _____
☐	☐ Abdomen _____
☐	☐ GU (as indicated) _____
☐	☐ Rectal (as indicated) _____
☐	☐ Back Strength/Extremities _____

Yes	No	
☐	☐	Ability to lift and carry up to 50 lbs. _____
☐	☐	Ability to exert up to 100 lb. Force or push/pull _____
☐	☐	Ability to bend/stand/squat/crawl _____

NL	ABNL	
☐	☐	Neuro _____
☐	☐	Reflexes _____
☐	☐	Lymph's _____
☐	☐	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: _____

Career & Technical Education

Rowan College of South Jersey

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	1st Step Date: _____ Results: _____ * If positive PPD result, see Chest Xray & Letter	2nd 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: _____

_____

_____

Continues on next page

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: _____