ADVANCED NURSE AIDE
Prerequisite Checklist

		DATE COMPLETED
1.	You must have an accepted DMACC Application for Admission on file (either you have been accepted to DMACC or been enrolled in the last 3 years). If not, you must complete an online DMACC application and select one of the following: (1) "Nurse Aide" as your major if you only plan on taking Nurse Aide classes OR (2) "Nursing (RN) – AAS" as your major if you are taking Nurse Aide as a prerequisite and plan to go on to DMACC's Nursing program. **https://www.dmacc.edu/admissions/Pages/apply.aspx** *Be sure to notify DMACC immediately if your name, address, or phone number changes after you apply.*	

PLEASE READ THESE INSTRUCTIONS CAREFULLY:

- **The forms, listed below, must be filled out completely and submitted to the Nurse Aide Office as a full packet. Completed forms should be submitted by emailing forms to CNA@dmacc.edu from your DMACC email address. Emails from personal email addresses will not be accepted. Forms may also be submitted in-person to the Ankeny Campus, Nurse Aide Office, Building 24-Room 308.**
- **Completed forms may be submitted on (or after) the date listed for the semester on the website.**
- **Once your forms are approved, you will receive more information about course registration via your DMACC email address. Available sections at the time of registration are based on seat availability.**

All paperwork, schedules and additional information can be found at:
https://www.dmacc.edu/programs/health/cna

	FORM	INSTRUCTIONS	FORM READY (✓)
2.	**PROOF OF SUCCESSFUL COMPLETION OF BASIC NURSE AIDE**	Submit a copy of your completion certificate or transcript showing successful completion of Basic Nurse Aide class at DMACC or another state-approved 75-hour nurse aide class. If you took your Basic Nurse Aide course at another institution, additional paperwork may be required.	
3.	**CRIMINAL ABUSE/ BACKGROUND CHECK FORM** (3 pages)	FORM 3: Read Directions FORM 3A: *"Notice & Release of Criminal Record/Child and Adult Abuse Registry Checks"* You may fill out your name, social security number, address and phone number. You must have a witness watch you sign this form and sign as a witness. Witnesses can be family, friends, etc. FORM 3B: *"State of Iowa Criminal History Record Check Request Form"* You may complete the gray section. Note: if you have had more than one last name in your lifetime, you must fill out a form for EVERY last name you have had (ex: maiden, married, adopted, etc.) Sign all forms with your current last name.	
4.	**PHYSICAL AND IMMUNIZATION FORM** (multiple pages)	This must be completely filled out and signed by your physician. "Part III: Required Test and/or Immunizations": all of your immunizations or tests must be complete, documented and the form must be signed. If you had a titer run, please attach a copy of your lab results. FORM A: *Background Information:* You may fill out this page and sign and date it. FORM B: *Medical History*: Your physician must complete this form and sign and date. FORM C: *Required Tests and/or Immunizations: I* Your physician must complete this form and sign and date.	

	FORM	INSTRUCTIONS	FORM READY (✓)
5.	**HEALTH AND PUBLIC SERVICES DEPARTMENT RECORD OF TB TESTING**	• Note: You MUST have TWO TB tests administered and read by a physician. The physician must sign this form. • There must be a minimum of 7 days between the date the first TB test is administered and when the second TB test is administered. • If you have a positive test, you will need to have and submit a report from a chest x-ray. See form for details.	
6.	**PROOF OF COMPLETION OF HEALTH CARE PROVIDER OR PROFESSIONAL RESCUER CPR**	Approved CPR Modules: • American Heart Association Basic Life Support (BLS) OR American Heart Association Heartcode (this is an online course followed by a face-to-face skills test) • American Red Cross CPR for the Professional Rescuer OR American Red Cross Health Care Provider course For a schedule of DMACC CPR classes go to: https://ce.dmacctraining.com/dmacc2/public/store/search.do?navigator=courseCategories and search under "healthcare" OR call DMACC Registration at (515) 964-6800 or (800) 342-0033.	
7.	**FLU VACCINE FORM**	Take this form with you to the location where you get your flu shot and have the provider fill it out, documenting that you received your shot. Required when taking classes from October through May only.	
8.	**COURSE ACKNOWLEDGMENT FORM**	Read this form carefully and sign, acknowledging what you've read.	

NURSE AIDE FREQUENTLY ASKED QUESTIONS (FAQ's):

(1) How do I get my Nurse Aide Certification so I can work as a C.N.A?
After completing the Basic Nurse Aide course successfully, you will have the opportunity to take the Nurse Aide written (NRAO858) and skills (NRA0859) tests for placement on Direct Care Worker Registry, which is your Nurse Aide Certification.

(2) Where can I find more information about the Nurse Aide program?
The DMACC Nurse Aide website has extensive information about the program and should answer most, if not all, questions you may have. Please consult the website first.
https://www.dmacc.edu/programs/health/cna

(3) Do I really need to get TWO TB tests or is one ok?
If you are getting traditional TB tests where they put fluid under the skin on your forearm then YES you must get two tests. However, if you are able to get the Quantiferon Gold or T-Spot blood tests you do not need to as these are ONE step tests.

(4) How do I submit my pre-requisite paperwork?
Dates packets can be submitted can be found on the Nurse Aide website. If it is within the timeframe for the semester you are wanting to take a Nurse Aide course, you can submit your packets one of these ways:

(1) Scan and email all forms to CNA@dmacc.edu
(2) Bring your paperwork in person to the Nurse Aide Office on the Ankeny Campus, located in Building 24-Room 308.

(5) Can I have someone review my paperwork before I email it in?
Yes, the Nurse Aide intake staff on each campus is happy to review your paperwork to make sure everything is complete prior to your sending it in. Please refer to the schedule of courses or Nurse Aide website for contact people on each campus.

Additional FAQ's can be found on the DMACC Nurse Aide website:
https://www.dmacc.edu/programs/health/cna

Des Moines Area Community College

Criminal/Abuse Background Checks

DMACC will complete Criminal/Abuse background checks on each student. Criminal convictions or documented history of abuse may prevent students from participating in clinical education experience. Students unable to participate in clinical education will be unable to complete the course requirements. The Department of Inspections and Appeals (DIA) regulations can be found on their website, http://dia.iowa.gov/

Criminal/Abuse background checks are processed at DMACC. Incomplete forms and forms or copies from outside sources will not be accepted.

Special Instructions:

FORM 3A: *"Notice & Release of Criminal Record/Child and Adult Abuse Registry Checks"*
You may fill out your name, social security number, address and phone number. You must have a witness watch you sign this form and sign as a witness. Witnesses can be family, friends, etc.

FORM 3B: *"State of Iowa Criminal History Record Check Request Form"*
You may complete the gray section. Note: if you have had more than one last name in your lifetime, you must fill out a form for EVERY last name you have had (ex: maiden, married, adopted, etc.) Sign all forms with your current last name.

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Notice & Release of Criminal Record/Child and Adult Abuse Registry Checks

I, the undersigned student in the Nursing Assistant program at Des Moines Area Community College (DMACC), understand that participation in a clinical experience is part of the Nursing Assistant program, and that this includes working at an affiliating agency. I further understand that the affiliating agencies have the right to establish requirements for participation in clinical experience and that the requirements may include submission to criminal record/child and adult abuse registry checks, based upon all current and former last names and aliases. Results of the criminal record/child and adult abuse registry checks will be released to the Department of Human Services (DHS) who will determine if the crime or founded abuse warrants prohibition from clinical education experience.

In accordance with DMACC's contract with affiliating agencies, results of the criminal record/child and adult abuse registry checks will be released to contracted agencies only upon request.

I understand and agree that if I am prohibited from participation in a clinical experience by DHS, or by an affiliating agency or if I refuse to submit to the registry checks that are required in order to participate in a clinical experience, I may be unable to complete my program of study. I hereby release DMACC, its employees, and all affiliating agencies from any liability with regard to my participation in a clinical experience and decisions made concerning my participation in a clinical experience.

Further, I give DCI (Department of Criminal Investigation) and DHS permission to release information to Des Moines Area Community College, which may be requested as a result of the criminal/child and adult abuse check.

Please Print

Name: _____

Social Security Number: _____

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

Phone Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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7/2006, 3/2010

STATE OF IOWA
Criminal History Record Check Request Form

DCI Account Number: _____
(if applicable)

To: **Iowa Division of Criminal Investigation**
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

From: _____

_____

_____

Phone: _____

Fax: _____

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	**First Name** (mandatory)	**Middle Name** (recommended)
Date of Birth (mandatory)	**Gender** (mandatory)	**Social Security Number** (recommended)
	☐ **Male** ☐ **Female**	

Waiver Information: **Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.**

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature: _____

Iowa Criminal History Record Check Results

(DCI use only)

As of _____, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI #_____

DCI initials_____

DCI-77 (08/25/10)

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INSTRUCTIONS FOR COMPLETING STUDENT HEALTH AND IMMUNIZATION RECORD

Health and Public Service Department Students need to complete and submit the Student Health and Immunization Record. The form must be thoroughly completed with health care provider (HCP) verification of current immunization, conditions requiring treatment, and/or special accommodation needs.

Complete documentation is necessary for assigning students to cooperating agencies for the practice component of the program. Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, he/she will be required to withdraw from the program.

HEPATITIS B, CHICKENPOX AND PERTUSSIS (Tdap) IMMUNIZATIONs:

All students must show proof of immunity to Chickenpox and documentation of current vaccination to tetanus, diphtheria and pertussis. If proving immunity by titers, lab reports documenting each titer must be attached to the form. Please read the vaccine information sheets available from the Center for Disease Control (CDC) at http://www.immunize.org/vis/ to learn the advantages and contraindications for Tdap, Chickenpox, Hepatitis B, and MMR. Information on TB testing is available at: http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

WHERE TO GET IMMUNIZED

If you are currently working in a health care facility, check with your employer to see if the 2-step TB test and vaccines are offered free of charge. Some insurance companies will cover the cost of the vaccines or titers (blood tests). If your insurance company will not cover the cost of the vaccination or titers, you will be responsible to cover the cost. Immunizations can be arranged through your private physician, County Health Department or the Ankeny campus nurse.

As you undergo immunization, it is very important not to miss an injection. If you cannot have an immunization, a medical waiver form must be completed and signed by your physician and accompany your immunization form.

Immunization records are required for most health care positions. Students must make a copy of their completed form for future job applications and file it with their important papers.

HEALTH AND IMMUNIZATION RECORD

Incomplete forms are unacceptable.

Before turning in your form please look it over very carefully to assure that:

- All sections (Part 4A, 4B and 4C) are completed
- There are no blank lines or missing signatures
- All lines are filled in and all signatures are present (Yes, it bears repeating! Health care providers must be detail oriented. Double-check your work)
- Information about health insurance is listed or "none" is indicated (Include insurance provider and your account number)
- Someone is identified for emergency notification if you are seriously ill or injured
- Dates of your last physical and dental exams are filled in
- Allergies to medications or other substances are listed or you have put "none known"
- You signed and dated the bottom of **Part 4A**
- Your health care provider completed, dated and signed the bottom of **Part 4B**
- Correct information is listed for each immunization or screening in **Part 4C**
  Please read the instructions for each item carefully.
- Your health care provider signed the bottom of **Part 4C**
- If you are using titers to show evidence of immunity, you must attach copies of laboratory tests for each titer

SUBMITTING FORMS:

Submit all completed forms as part of a completed Advanced Nurse Aide packet. Scan and email the full packet to CNA@dmacc.edu or bring, in person, to the Ankeny Campus Nurse Aide Office, Building 24-Room 308. Emails must be submitted from your DMACC email address**.**

- DMACC campus libraries have scanners available for student use.
- **Keep original copies for yourself for future needs** (When you get a new job any health care employer will ask you to provide documentation of your immunizations).

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4A

HEALTH AND PUBLIC SERVICES DEPARTMENT
STUDENT HEALTH AND IMMUNIZATION RECORD

Program in which you are enrolling: _____ Campus: _____

All students enrolling in the health and early childhood programs must complete Part I of this form before consulting with a health care provider (MD/DO, PA, NP) to verify dates of immunizations and treatment of current or chronic conditions. With the exception of immunization information or in the case of medical emergencies, no information will be released to anyone other than the Health and Public Service Department without consent of the student.

Program continuation requires each student to perform every essential function of the student role. If the student, with reasonable accommodation, is unable to perform any essential function in a safe and successful manner, they will be required to withdraw from the program.

BACKGROUND INFORMATION **To be completed by student.** ***(Please Print)***

A. PERSONAL DATA : ☐ ☐ DMACC ID Number: 900

Last Name	First Name	Middle Initial	Date of Birth

Home Address (Number and Street)	City	State	Zip Code

Telephone: Home	Work	Health Insurance Company/Policy Number
	( )	( )

In Case of Emergency, Notify: Name	Relationship	Home Phone	Work Phone

B. **PERSONAL HEALTH HISTORY**

DATE OF MOST RECENT DENTAL EXAM _____
month year

ALLERGIES: If none, write "None Known" below

Medication: _____

Other Types: _____

I have the following "Med-alert" condition: _____

OTHER COMMENTS:

_____ _____
Student Signature Date

• **Part 4B: Medical History & Part III Immunizations**

4B

TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER

MEDICAL HISTORY

Student Name _____

1. **Physical/mental conditions which have required treatment within the last 6 months or are chronic in nature:**

_____

_____

_____

_____

2. **Medications taken currently or routinely:**

_____

_____

_____

3. **Conditions which restrict activity and/or require special adaptation(s):**

_____

_____

_____

_____

4. Other:

_____

_____

_____

5. **Core Performance Standards**:

Please refer to the attached **Iowa Core Performance Standards for Health Career Programs** and indicate if the above named individual may have difficulty meeting any of the eleven standards outlined.

At this time this individual is capable of meeting the performance standards:

____ Agree

____ Disagree. The following limitations are present_____

____ Additional evaluation suggested _____

6. **Date of last physical exam:** _____

mm/dd/yr

_____ _____

Date **Signature of Health Care Provider (MD, DO, ARNP, PA)**

Iowa Core Performance Standards for Health Care Career Programs

Iowa Community Colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in healthcare careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution's ADA policy.

Capability	Standard	Some Examples of Necessary Activities (Not All-Inclusive)
Cognitive-Perception	The ability to perceive events realistically, to think clearly and rationally and to function appropriately in routine and stressful situations.	• Identify changes in patient/client health status • Handle multiple priorities in stressful situations
Critical Thinking	Critical thinking ability sufficient for sound judgment.	• Identify cause-effect relationships in clinical situations • Develop plans of care
Interpersonal	Interpersonal abilities sufficient to interact appropriately with individuals, families and groups from a variety of social, emotional, cultural and intellectual backgrounds.	• Establish rapport with patients/clients and colleagues • Demonstrate high degree of patience • Manage a variety of patient/client expressions (anger, fear, hostility) in a calm manner
Communication competently	Communication abilities in English sufficient for appropriate interaction with others in verbal and written form.	• Read, understand, write and speak English • Explain treatment procedures • Initiate health teaching • Document patient/client responses • Validate responses/messages with others
Mobility	Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting, supporting and/or transferring a patient/client.	• The ability to propel wheelchairs, stretchers, etc., alone or with assistance as available
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective care and documentation.	• Position patients/clients • Reach, manipulate and operate equipment, instruments and supplies • Electronic documentation/keyboarding • Lift, carry, push and pull • Perform CPR
Hearing	Auditory ability sufficient to monitor and assess, or document health needs.	• Hears monitor alarms, emergency signals, auscultatory sounds, cries for help • Hears telephone interactions/dictation
Visual	Visual ability sufficient for observation and assessment necessary in patient/client care, accurate color discrimination.	• Observes patient/client responses • Discriminates color changes • Accurately reads measurement on patient/client-related equipment
Tactile	Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature and texture.	• Performs palpation • Performs functions of physical examination and/or those related to therapeutic intervention, e.g., insertion of a catheter
Activity Tolerance	The ability to tolerate lengthy periods of physical activity.	• Move quickly and/or continuously • Tolerate long periods of standing and/or sitting
Environmental	Ability to tolerate environmental stressors.	• Adapt to rotating shifts • Work with chemicals and detergents • Tolerate exposure to fumes and odors • Work in areas that are close and crowded • Work in areas of potential physical violence

4C

Name_____ DMACC ID _____ Due date: _____

Required Test and/or Immunizations

This form is to be completed, signed and dated by a licensed health care provider (MD, DO, ARNP, PA). Take your immunization records and documentation of disease with you to your appointment. If immunization records are not available, the HCP will determine what vaccinations tests or titers are indicated.

Documentation of the items below are required by the clinical agencies DMACC contracts with for clinical experience.

Adult Diphtheria/Tetanus/Pertussis All healthcare personnel (HCP) who have not or are unsure if they have previously received a dose of **Tdap** should receive a one-time dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Then, they should receive Td boosters every 10 years thereafter. HCP Vaccination Recommendations Centers for Disease Control and Prevention, March 2011.	**Date of Tdap** mm/dd/yy Once in a lifetime booster required for Pertussis protection

Varicella (Chicken Pox) Evidence of Immunity includes any one of the following: • Positive titer • Two doses of vaccine • Documentation by HCP of chickenpox or herpes zoster. **Verbal history is not acceptable**	**Must attach copy of Lab results**		Vaccination #1 Date mm/dd/yy	Vaccination #2 Date mm/dd/yy
	Titer Date mm/dd/yy	Titer Results		
		Copy of lab results		

MMR All students (regardless of age) must have documentation of either 2 MMR vaccinations **OR** Documentation of sufficient titers for Rubeola, Mumps and Rubella. Those who have an "indeterminate" or "equivocal" level of immunity upon testing should be considered non-immune. **Lab results of titers must be attached to this form.**	**Titers**	**Titer date** mm/dd/yy	Titer results **Must attach copy of Lab results**	If born 1957 or later, 2 doses of live measles and mumps vaccines given on or after the first birthday, separated by 28 days or more.	
				Date MMR #1 mm/dd/yy	**Date MMR #2** mm/dd/yy
	Rubeola IgG		Copy of lab results		
	Mumps IgG		Copy of lab results		
	Rubella		Copy of lab results		

I certify this student has received the immunizations as indicated above or has laboratory evidence of immunity which is attached to this form.

_____ _____ **Date:** _____

Print Name of Health Care Provider **Signature of Health Care Provider (MD, DO, ARNP, PA)**

_____ (_____)_____

Address of Health Care Provider **City** **State** **Zip** **Phone**

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HEALTH AND PUBLIC SERVICES DEPARTMENT RECORD OF TB TESTING

Complete the information below completely. (Please print)

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ DMACC ID # _____ Program _____ Campus _____
Yearly TB testing is now required of health care workers in cooperating agencies. Nurse Aide students must have this completed before registering for classes.

This section must be completed and signed by your physician (or designee).

- If using 2-step PPD Skin Test by Mantoux (NOT TINE): a time period of more than 7 days but less than 1 year will be needed between TB skin test #1 and #2. Induration greater than 10.0 mm requires chest X-ray and prophylactic treatment consideration. Thereafter, an annual TB test (single step only) will be required.
- Quantiferon Gold blood test or T-spot TB blood test will also be acceptable and must be done annually. Documentation of lab results required.

TB SKIN TEST	**Date Placed** mm/dd/yy **Include time, site and signature of administrator**	**Date Read** mm/dd/yy **Include time**	**Results in mm induration***	**Signature of reader**
#1 TB skin test				
#2 TB skin test				

*If POSITIVE Test complete the following:

	Date of Chest X-Ray	**Chest X-Ray results**
Chest X-Ray		Copy of signed Chest x-ray report required
Is treatment plan indicated? Check one: ☐ **Yes** ☐ **No**	**If treatment plan is indicated please describe below.**	

Date _____ Signature of Physician (or designee) _____ Phone _____

Address _____

City/State/Zip _____

Rev. 2/2020

DMACC
DES MOINES AREA COMMUNITY COLLEGE

NURSING ASSISTANT PROGRAM
RECORD OF INFLUENZA VACCINATION

Annual Influenza Vaccination is required of Nursing Assistant Students who have clinical contact October through May.

SECTION A **Please Print**
Students: complete the information below and submit with your completed packet.

Last Name _____ First Name _____ Middle Initial ____

Date of Birth _____ DMACC ID Number _____

Program _____ Campus _____
HSC 172/HSC 182

Students must have this record completed during flu season, October through May.

SECTION B
This section must be completed and signed by the person administering the flu vaccination.

Check one:

☐ **This vaccine is contraindicated for this person at this time due to:**

_____

_____ _____
Signature and Title **Print Name**

☐ **This verifies that an Influenza Vaccination was given to the person named above on:**

Date administered: _____

Administered by:

_____
Signature and Title of Vaccine Administrator

_____
Print Name

_____ ( ) _____
Address Phone

_____
City/State/Zip

COURSE ACKNOWLEDGEMENT FORM
NURSE AIDE 75-HOUR or ADVANCED NURSE AIDE

Term (check one):

- ☐ Fall
- ☐ Spring
- ☐ Summer

Name _____ DMACC ID # _____

DMACC email _____

Please initial each statement below to verify you have read and understand them.

____ I acknowledge that I am responsible for knowing the course meeting dates, days, times and location of the Nurse Aide course for which I will be registering.

____ I understand I am required to be present the first day of class or I will be dropped and unable to continue the course.

____ For web-blended courses: I understand I will need to log in the first day the course is available to be counted as present. Otherwise, I will be dropped and unable to continue the course.

____ I understand the allowable limits for course absences are as follows. Absences beyond this will result in a failing grade and I will no longer be able to attend class.

- 3 hours of the classroom section (theory) - this limit does not apply to web-blended courses
- 1.5 hours of lab
- 3 hours during the clinical rotation.

Signature _____ Date _____