COLORADO NURSES AIDE SCHOOL, Inc.
NURSE AIDE PROGRAM

ENROLLMENT INFORMATION

Congratulations on your decision to become a Nurse Aide. You will be joining the exciting, challenging, and rewarding field of health care. You have made a wise choice to learn important skills in the rapidly growing area of long-term care, patient care skills.

Nurse Aides are the "heart" of long-term care, devoted to improving the quality of life residents. Your skills, along with a caring attitude, will be rewarded with the friendship and trust of the residents, the respect of your employer and co-workers, and personal satisfaction.

6460 EAST YALE AVE, UNIT G30
DENVER, COLORADO 80222

303-757-5858

www.coloradocnaschool.com

NURSE AIDE TRAINING
What is a Nurse Aide?

A Nurse Aide or Nursing Assistant is a very caring person who sees the purpose in his/her life as giving care and assistance to patients/residents so they may be comfortable, safe, and in the best state of wellness they can be. These Aides always work under the supervision of a licensed nurse. The focus of the program is on long term care facilities although Nurse Aides can be employed in hospital, home health care or other healthcare settings.

Some of the basic tasks they perform are:

- **Taking and recording vital signs**
- **Bathing the patient; exercising with the patient/resident**
- **Changing the patient's bed linens**
- **Helping with teeth brushing, nail care, hair care**
- **Help with feeding when necessary**
- **Keeping the patient/resident's room safe and tidy**

Aside from these tasks, the one fulfilling opportunity an Aide will always have is talking to and listening to the patient/resident. These people are often sick, scared, in pain, confused, sad, lonely, and experiencing very stressful situations. Pills and doctors do not always cure all ills. A listening ear and a hand to hold can often make a world of difference in someone's day and life!

How Do I Get Enrolled or Registered?

1. Select days and time you are willing to attend the training.

- 1ST OPTION-$1250.00
  M-T-TH-F 930am-4 pm

- 2nd OPTION-$1250.00
  M-T-TH-F 830am-330 pm

- 3rd OPTION-$1350.00
  M-T-TH-F 1pm-730 pm- Higher tuition will apply.

- 4th OPTION-$1400.00
  WEEKENDS (5)-SAT & SUN 7am-5 pm - Higher tuition will apply.

- 5th OPTION-$1500.00
  ACCELERATED PROGRAM- Higher tuition will apply.
  WEEKENDS (3 1/2)-SAT & SUN 6am-1030 pm

2. Call COLORADO NURSES AIDE SCHOOL to ensure that space is available in the class you have selected by calling -303-757-5858 or email to info@coloradocnaschool.com

3. Register by phone or by coming in to the school to fill out an application. Deposit of $ 450.00 must be paid upon registration.

4. **TUITION & FEES (Tuition includes):**
   - Textbooks and workbook
   - Uniform (Scrubs)
   - Gait belt
   - CBI Check (Criminal Background Check, including social security validity check, violent sexual offender and predatory registry search)
   - Student ID Badge
   - Professional Liability Insurance

Payment arrangements can be made with the school and the student is responsible to pay the remaining balance of tuition prior to graduation.

Refund Policy

- Students who cancel within 3 business days are entitled to a 100% refund of all tuition and fees paid prior to initiation of the student agreement.
- Students who withdraw after the 3rd business day of acceptance into the program, but before the commencement of classes are entitled to a 75% refund of tuition paid.
- Students are entitled to a 50% refund after the first 24 hour of the start of class.
- Students are entitled to a 25% refund if cancels at the end of the first week of class.

All refunds will be made within 30 days from the date of termination. The official date of termination or withdrawal of a student shall be determined.

If a student is dismissed from the program they will forfeit all monies paid.

5. Other school supplies needed by the student: comfortable shoes and socks, a watch with a second hand, notebook, a pen and pencil and a highlighter.

What Must I Do Before I Begin Class?

You must bring documentation of these requirements with you the first day of class. You will NOT be admitted to class if these items are not complete.

1. HEALTH INFORMATION FORM / PHYSICAL

Documentation of a physical **must** include that **the student is:**

a. able to lift 40 pounds to waist level without any physical limitations or restrictions

b. free from communicable disease

2. PPD – **2-step Tuberculin** must be administered and results read within **one year** of the start of the class. A PPD expiring during the course of the class will require an annual (one-step) PPD in addition to proof of the two-step PPD. Or **written report of chest x-ray, if PPD is positive. Denver Health TB Clinic 605 Bannock St. Denver, Co. 80204 does offer TB testing for small fee.**

3. CBI –Criminal History Record Information must be less than 1 year old from class start date: Will be done by school.

Dress Code

Uniform or scrubs are **mandatory** daily attire unless otherwise specified in writing.
Undergarments: Appropriate to style of uniform.
Shoes: Clean white polished; clinical, low heel, non-skid soles or sneaker.
Fingernails: Must be no longer than 1/8 inch (including acrylic), only clear un-chipped nail polish may be worn.
Wristwatch: A wristwatch is mandatory and must have a second hand.
Personal Hygiene: Daily bath/shower with soap and water. Use of antiperspirant or deodorant. Hair should be clean and neatly groomed, worn off the collar and secured away from face. Men with facial hair should be clean shaven with neatly trimmed beards, mustaches or sideburns.
BRING a notebook, pen, pencil, and highlighter for the **first day** of class.

MANDATORY ATTENDANCE:

Students must complete the total of 102 hours of theory, laboratory practice and 2 days of clinical internship to receive a "certificate of completion."

COLORADO NURSES AIDE SCHOOL
NURSE AIDE PROGRAM

APPLICATION FOR ADMISSION

Date __________

Name ____
(Last) (First) (Middle)

Date of Birth _______________Social Security Number _______________________

Home Address:
____

Phone # (home) _______________ (cell) _______________ (work) _____________

Email Address (if applicable): ____

APPLICANT EDUCATION

Dates	Name and Location of Educational Institution/School	Specialty, Certificate, Diploma

APPLICANT EMPLOYMENT EXPERIENCE

Dates	Name and Location where Employed	Duties

SPECIAL TRAINING IN HEALTH CARE FIELDS

Dates	Name and Location of Training Classes	Specialization

EXPERIENCE IN HEALTHCARE FIELDS

Dates	Any Healthcare Experience	Duties

Are you able to perform the essential job functions required for this profession? **Yes** ☐ **No** ☐

Are you a Citizen, or Legally Authorized to work in the U.S.? You're Status: ________________________

Have you ever been convicted of a Misdemeanor or Felony? **Yes** ☐ **No** ☐

If yes, please provide dates, and explanation in details of any convictions including City/State:____
____
____

APPLICANT REFERENCES

Name	Position	Phone Number/Email	How Long Known

Please check ( ) the class you would like to attend:

- ☐ 1ST OPTION-$1250.00
  M-T-TH-F 930am-4 pm

- ☐ 2nd OPTION-$1250.00
  M-T-TH-F 830am-330 pm

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Applicant's Signature: ________________________________ Date ____________

Interview Conducted by: _______________________________ Date ____________

Test Score: __________

Program Coordinator Signature _________________________________
Date______________

BACKGROUND RESEARCH RELEASE

Please read this section carefully and acknowledge your understanding and acceptance by initialing and signing below statements.

I certify that all the following statements are true, correct, and complete to the best of my knowledge.

____ **Consent to conduct Background Investigation**

As a condition of, and in consideration for, admission to the Nurse Aide Program at Colorado Nurses Aide School, I give my permission to investigate my personal and employment histories and criminal background. I understand that this background investigation will include, but not limited to, verification of all provided information, criminal and driving record, interviews past employers and listed references

____ **Cooperation with Investigation**

I agree to cooperate with all background investigations deemed necessary or required and to sign any waiver or releases that may be necessary to obtain access to my personal information.

____ **Falsification Statement**

I understand that any falsification and/or omission of fact made by me in this application or in connection with any background investigation may be sufficient grounds for rejection of this application for admission, or if discovered after admission, for immediate dismissal from the Program.

Applicant Signature: ___________________________________Date: ______________

Applicant Printed Name:____

COLORADO NURSES AIDE SCHOOL

HEALTH INFORMATION FORM

NAME ____DATE________________

ADDRESS: ____

BIRTHDAY_________________ PHONE (H) ____________________(C)________________________

IN CASE OF EMERGENCY NOTIFY: _______________________________________(NAME)

ADDRESS ____PHONE____________________

PERSONAL HISTORY (to be completed by student)

ALLERGIES (please specify)	YES	NO
Drugs ______________________	☐	☐
Food ______________________	☐	☐

Other ________________________________

____

____

COMMUNICABLE DISEASES	YES	NO
Scarlet Fever____________________	☐	☐
Chicken Pox____________________	☐	☐
Malaria________________________	☐	☐
Mononucleosis__________________	☐	☐

Other ________________________________

____

____

SURGERIES:

____

____

____

____

ACCIDENTS (Please List):

____

____

____

____

HEALTH PROBLEMS	YES	NO
Eye Problems	☐	☐
Ear, Nose, Throat	☐	☐
Insomnia	☐	☐
Head Injuries	☐	☐
Headaches	☐	☐
Tuberculosis	☐	☐
Chest Pain/Pressure	☐	☐
Chronic Cough	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Muscular Problems	☐	☐
Skeletal / Joints Problems	☐	☐
Back problems/Injury	☐	☐
Seizures	☐	☐
Stomach/Intestinal Problems	☐	☐
Gallbladder Problems	☐	☐
Hernia	☐	☐
Weakness, Paralysis	☐	☐
Psychiatric Problems	☐	☐
Hepatitis A, B, C	☐	☐

Other ___________________________

____

STUDENT SIGNATURE ____DATE ______________

HEALTH EXAM (to be completed by Physician or Registered Nurse/Nurse Practitioner)

HEIGHT _________________ WEIGHT ________________PULSE _____________________
BLOOD PRESSURE _________________ RESPIRATION ______________
HEARING STATUS: Normal __________ Deficit _____________________
VISUAL STATUS : L = 20/ __________ R = 20/ _____________________

REVIEW OF SYSTEMS (please check):

	Normal	**Abnormal**	**Comments**:
1. Head, Neck	☐	☐	__________________________________
2. Lungs	☐	☐	__________________________________
3. Gastrointestinal	☐	☐	__________________________________
4. Genitourinary	☐	☐	__________________________________
5. Muscular	☐	☐	__________________________________
6. Skeletal	☐	☐	__________________________________
7. Neurological	☐	☐	__________________________________
8. Other	☐	☐	__________________________________

IMMUNIZATION RECORD (Required):

Negative two-steps TUBERCULIN TEST: Date _____________ Result: ______________________
Negative Chest X-RAY within Last Year: Date _____________ Result: ______________________
Diphtheria/Tetanus within past 10 Years? ____

Please attach proof of Immunizations

Please Check Below Activity You Recommend:

☐ All Forms of Physical Activity
☐ Activity Restrictions

Comments: ____

Summary of General Health Status: ____

Date ________________________ Signature: ____________________________________
Examining Health Professional

Address: ____

Health Care Institution: ____