KENNESAW STATE UNIVERSITY
COMMUNITY AND PROFESSIONAL EDUCATION

CNA CERTIFICATE PROGRAM APPLICATION PACKET

Application Instructions

Thank you for your interest in the Certified Nursing Assistant Certificate Program with Kennesaw State University's Community and Professional Education. Please read the following instructions carefully.

Type or print this application in blue or black ink.

To be considered for this program, please complete and return ALL sections of the Application Packet:

- **Skills Assessment & Program Application** *(Taken online through our website. Results automatically sent to KSU.)*
- **Student Information**
- **Release, Waiver of Liability & Covenant Not To Sue**
- **Background Check & Drug Screen Acknowledgement**
- **Health History & Immunizations** *(Must be completed by Healthcare Provider. If you have Titers, you must attach a laboratory report.)*
- **Negative QuantiFERON-Gold or T-spot blood test results only. TB skin test will NOT be accepted.**
- **GA Form 3231 Immunization Certificate or other official immunization record**
- **American Heart Association BLS Provider Card** *(Must be from the American Heart Association)*
- **Driver's License**, front and back *(must be clear color copy)*
- **Signed Social Security Card**, front and back *(must be clear color copy)*

HOW TO RETURN COMPLETED APPLICATION PACKETS:

In Person:
Please deposit in BLACK BOX near enrollment window.
KSU Center (South Entrance)
Attn: Healthcare Applications
3333 Busbee Drive
Kennesaw, GA 30144

By Fax:
470-578-9083

Email:
cpecna@kennesaw.edu

IF SUBMITTING DIGITAL APPLICATION, ONLY SUBMIT ONCE ----- AFTER THAT, EMAIL, FAX, OR USE DROP BOX

Estimated Expenses

Students will be responsible for the following items. More information and directions on how and when to purchase will be provided during the first night of class. These are minimum, estimated costs to help you plan accordingly.

- Criminal Background Check, Drug Screen $80** (Completed after class begins)
- Seasonal Flu Shot and COVID Shot $40**
- Ceil Blue Scrubs $50
- White Shoes $50
- Stethoscope $60
- Blood Pressure Kit $30

** Students in the Certified Nursing Assistant Certificate Program will be required to complete a criminal background check, drug screen, seasonal flu shot, and seasonal COVID shot. Based on the results of the criminal background check and drug screen, hospitals or clinical facilities where you will participate in onsite training may deny you access to their facility – resulting in your inability to successfully complete the Certified Nursing Assistant Certificate Program. If you are unable to complete the clinical portion of your training, you will be unable to complete the program.

Textbooks are required for the program and are available at the KSU Bookstore. For more information, visit bookstore.kennesaw.edu or call (470) 578-2342. You may also purchase your textbooks from another vendor, just be sure to check the title, edition, and ISBN number is correct.

Student Information

Personal Information

NAME ____

Last *First* *Middle* *Maiden*

ADDRESS ____

Street *City* *State* *Zip*

PHONE ( ) ( ) ( )

Daytime *Cell* *Evening*

EMAIL ____

All correspondence regarding the program will be sent to this email address

DATE OF BIRTH: ____________________

Short Answer

Why do you want to become a Certified Nursing Assistant?

I affirm, agree, and/or understand that all statements on this form are true and accurate; any misrepresentation or omission of material facts may result in removal from the program.

Signature of Student *Date*

FOR OFFICE USE ONLY:

Date Received:

RELEASE, WAIVER OF LIABILITY & COVENANT NOT TO SUE

(READ CAREFULLY BEFORE SIGNING AND BRING TO FIRST CLASS SESSION)

The undersigned hereby acknowledges that participation in off-site excursions, classes and recreational activities involves inherent risks of physical injury and assumes all such risks. The undersigned hereby agrees that for the consideration of Kennesaw State University allowing the undersigned to participate in off-site excursions, classes or recreational activities and, in connection therewith, making available to the undersigned for facilities, grounds, or personnel of the institution, the undersigned participant does hereby waive liability, release and forever discharge the institution and the Board of Regents of the University System of Georgia, its members individually, and its officers, agents and employees of and from any claims, demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, including death, resulting from my voluntary participation in or in any way connected with such off-site excursions, classes or recreational activities.

I further covenant and agree that for the consideration stated above I will not sue the institution, the Board of Regents of the University System of Georgia, its members individually, its officers, agents, or employees for any claim for damages arising or growing out of my voluntary participation in off-site excursions, classes or recreational activities.

I understand that the acceptance of this release, waiver of liability and covenant not to sue the institution of the Board of Regents of the University System of Georgia or any agent or employees thereof, shall not constitute a waiver, in whole or in part of sovereign or official immunity by said Boards, its member, officers, agents, and employees.

Further, I understand that this release, waiver of liability, and covenant not to sue shall be effective during the time period indication below while I am participating in activities sponsored by Kennesaw State University.

COURSE NAME________________________ DATES___________________________

_____ I authorize Community and Professional Education at KSU to share this information with the instructor(s). Please check.

Signature:_______________________________ Date:_____________________________

Participant or Legal Guardian if participant under the age of 18.

Print Name:____

Emergency Contact Name & Telephone Number:

Please list any special health problems/allergies/medications:

Background Check & Drug Screen Acknowledgement

This form is not a Background Check. After program begins, you will receive instructions to complete a background check and drug screen. Background Check results determine your eligibility to participate in the Certified Nursing Assistant Certificate Program.

Personal Information

NAME ____

Last *First* *Middle* *Maiden*

EMAIL ____

I understand I will need to complete a Background Check and Drug Screen as part of the eligibility requirements of the Certified Nursing Assistant Certificate Program.

____ ________________

Signature of Applicant *Date*

FOR OFFICE USE ONLY:

Date Received:

Health History & Immunizations

This form must be completed and signed by your Healthcare Provider. ATTACH GA FORM 3231 TO THIS PAGE.

Personal Information

NAME ____________________ **DATE OF BIRTH** ____________

Immunization History

***** IF YOU HAVE TITERS, PLEASE ATTACH VALUES REPORT *****

COVID

1st Dose Date: ____________ *MANUFACTURER: ** ____________

**Must have completed all doses depending on manufacturer*

2nd Dose Date: ____________ *MANUFACTURER: ** ____________

3rd Dose Date: ____________ *MANUFACTURER: ** ____________

A copy of the COVID CDC Vaccination Card must accompany this application packet.

TB TESTS

*****Negative QuantiFERON-Gold or T-spot blood test results only. TB skin test will NOT be accepted.*****

QuantiFERON-Gold Test

Date: ____________ Result: ____________

____

Current treatment for latent TB, please indicate medication dose, frequency and duration: ____________

Provider Signature: ____________ **Date** ____________

T-spot blood test

Date: ____________ Result: ____________

____

Current treatment for latent TB, please indicate medication dose, frequency and duration: ____________

Provider Signature: ____________ **Date** ____________

TETANUS/DIPHTHERIA/PERTUSIS (Tdap or Td)

**** Not older than 10 years ****

Tdap Date: ____________ OR Td Date: ____________

MEASLES, MUMPS, RUBELLA (MMR)

**** Must have 2 immunizations OR Positive Titer ****

Date of Immunization #1: ____________ #2 ____________

Positive Measles Titer Date: ____________

Positive Mumps Titer Date: ____________

Positive Rubella Titer Date: ____________

HEPATITIS B

**** Must have 3 immunizations OR Positive Titer ****

Date of Immunization #1: ____________ #2: ____________ #3: ____________

Positive Titer Date: ____________

VARICELLA	INFLUENZA VACCINE
**** Must have 1 of the following ****	**** Must have current season ****
Date of Vaccine: ____________	Date of Vaccine: ____________
Positive Titer Date: ____________	

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

The student above is capable of performing duties as a Certified Nursing Assistant (CNA).

Healthcare Provider Signature: ____________ **Date:** ____________

Healthcare Provider Name (Print): ____________

Address: ____________

Phone Number: ____________

Required Proof of Immunization

INFLUENZA VACCINE

- Student **MUST** provide proof of vaccine administration if clinical experience starts or ends during Flu Season (October through March).
- Proof of vaccine administration must include the date of vaccination, the location where vaccine was administered. (i.e., Left deltoid), and the signature of the person who administered.
- If Student answers No on the Health History form, a reason must be selected from those listed on the form supported by a note from Primary Care Physician.

TDAP/TD VACCINE

- Student **MUST** provide proof of vaccine administration.

MMR IMMUNIZATION

- **Student BORN BEFORE 1957 MUST** provide one of the following as proof of immunity to MMR:
  1. A positive titer for Rubella (German Measles) OR
  2. A Rubella vaccine OR
  3. One dose of MMR vaccine
- **Student BORN AFTER 1957 MUST** provide one of the following as proof of immunity to MMR:
  1. Proof of 2 MMR vaccines OR
  2. Proof of 1 MMR vaccine and one Rubeola (Red Measles) vaccine OR
  3. Proof of 1 MMR Vaccine and positive titer for Rubella OR
  4. Proof of positive titers for Rubeola and Rubella

HEPATITIS B IMMUNIZATION

- Student **MUST** provide one of the following as proof of immunization for Hepatitis B:
  1. Proof of 3 Hepatitis B vaccines OR
  2. Proof of Positive titer for Hepatitis B antibody

VARICELLA IMMUNIZATION

- Student **MUST** provide one of the following proofs of immunization for Varicella (Chicken Pox):
  1. Childhood Immunization Record showing 2 doses of vaccine OR
  2. Proof of Positive titer for Varicella - If the titer is negative, student must provide proof of booster vaccine

TUBERCULINE VACCINE

REQUIRES Annual QuantiFeron-Gold or T-Spot Blood Test. TB Skin tests are not accepted.

- Student MUST provide proof of current negative QuantiFERON-Gold or T-Spot blood test result to attend clinical experience. The test result must be valid for the duration of the clinical experience.
- Student with previous proof of positive test, must provide current QuantiFeron-Gold or T-Spot blood test result

TB POSITIVE RESULTS

- If Student has a new Positive Test result, student **MUST** provide the following for clearance:
  1. Proof of NEW POSITIVE QuantiFERON–Gold or T-Spot blood test result which must be valid for the duration of clinical experience less than 1 year old AND
  2. A current negative/normal Chest X-Ray which must be valid for the duration of clinical experience (one year from clinical experience End Date) AND
  3. Evidence of INH or RIFAMPIN TREATMENT which includes the following:
     a. Copy of the new prescription AND
     b. Picture of first filled bottle showing the student’s name, medicine name and date prescription was filled

COVID VACCINATION

Participation in clinical rotations within healthcare programs—whether in hospitals, nursing homes, assisted living communities, or other settings involving direct patient care—requires students to be vaccinated against COVID-19 for the current season. This requirement is being set forward to continue partnerships with our community partners and cultivate a community of safety for our immunocompromised, rehabilitating, and elderly patients.

****Any declination must be approved by the clinical site using the site-specific declination form prior to clinical rotations.****

Application Packet Checklist

Complete entire Application.

Incomplete packets will NOT be reviewed.

- ☐ Complete online **Skills Assessment & Program Application**
- ☐ Complete **Student Information section**
- ☐ Read, fill out, and sign the **Release, Waiver of Liability & Covenant Not To Sue**
- ☐ Read, fill out, and sign the **Background Check & Drug Screen Acknowledgement**
- ☐ Complete **Health History & Immunizations Form.** Healthcare provider must fill out and sign all sections of this form.
  *Include value report for any titers
- ☐ Include lab results for **QuantiFERON Gold TB Test**
  *Include copy of Negative lab test OR titers/if +, submit current letter of treatment good through externship
- ☐ Submit copy of **GA Form 3231** or other official immunization record
  *This form can be obtained from your physician or health department
- ☐ **American Heart Association BLS Provider Card**
  *We accept only American Heart Association
- ☐ Include a **color copy, front and back** of your **Driver's License**
- ☐ Include a **signed color copy, front and back** of your **Social Security Card**

If you are submitting the digital application, ONLY SUBMIT ELECTRONICALLY ONCE. Send additional documents through FAX, EMAIL, OR DROP BOX