

# CNA CERTIFICATE PROGRAM APPLICATION PACKET

## Application Instructions

Thank you for your interest in the Certified Nursing Assistant Certificate Program at the College of Continuing and Professional Education at Kennesaw State University. 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:**

1. **Skills Assessment & Program Application** (Taken online through our website. Results automatically sent to KSU.)
2. **Student Information**
3. **Release, Waiver of Liability & Covenant Not To Sue**
4. **Background Check Information**
5. **Health History & Immunizations** (Must be completed by Healthcare Provider. If you have Titters, you must attach a values report. Must have 2 TB tests.)
6. **Hepatitis B Declination Form** (Must be completed if you didn't receive the vaccine series or have Titters)

**Students must also provide a clear copy of the following with their Application Packet:**

7. Driver's License
8. Social Security Card

### HOW TO RETURN COMPLETED APPLICATION PACKETS

#### In Person:

KSU Center (South Entrance)  
Attn: Healthcare Applications  
3333 Busbee Drive  
Kennesaw, Georgia 30144

#### By Mail:

KSU Center, Registration Department  
Attn: Healthcare Applications  
3333 Busbee Drive, MD 3301  
Kennesaw, Georgia 30144-5591

## 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\*\*
- Seasonal Flu Shot \$20\*\*
- 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 an additional criminal background check, drug screen, or seasonal flu shot prior to participation in the onsite clinical externship portion of the program. 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.

#### TB Skin Test Locations

East Cobb Healthcare Center  
4938 Lower Roswell Road  
(678) 784-2180

Hours: M-W 8-11am & 1-4pm, Friday by appointment only

Cost: \$31

Flu Shot: \$15-25

Marietta Health Center  
1650 County Services Pkwy.  
(770) 514-2300

Hours: M, W, F 8-11am & 1-4pm

Cost: \$31

Flu Shot: \$25

Textbooks are required for the program and available at the KSU Center Bookstore. For more information, visit [bookstore.kennesaw.edu](http://bookstore.kennesaw.edu) or call (470) 578-2342. The KSU Center Bookstore is open Monday – Thursday from 4-8pm and Saturday from 8:30-11:30am.

# Student Information

Personal Information				
<b>NAME</b>	_____			
	<i>Last</i>	<i>First</i>	<i>Middle</i>	<i>Maiden</i>
<b>ADDRESS</b>	_____			
	<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<b>PHONE</b>	( )	( )	( )	
	<i>Daytime</i>	<i>Cell</i>	<i>Evening</i>	
<b>EMAIL</b>	_____			
	<i>All correspondence regarding the program will be sent to this email address</i>			
<b>PERSONAL:</b>	_____			
	<i>Date of Birth</i>			

## 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: \_\_\_\_\_



College of Continuing  
and Professional Education

**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 Continuing 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 Information

*This form must be returned to begin the Background Check process*

The information included on this form will be used to contact you to complete a Background Check. This form is not a Background Check. A member of Kennesaw State University’s HR Department will contact you via email and provide you with instructions to complete an online Background Check. There is no fee associated with this background check. Please complete the process as soon as possible. Background Check results determine your eligibility to participate in the Certified Nursing Assistant Certificate Program.

Personal Information			
<b>NAME</b>			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
	<i>Maiden</i>		
<b>EMAIL</b>			
<p>I understand I will be contacted by a member of KSU’s HR department to undergo a Background Check as part of the eligibility requirements of the Certified Nursing Assistant Certificate Program.</p>			
<i>Signature of Applicant</i>			<i>Date</i>
<b>FOR OFFICE USE ONLY:</b>			
Date Received:			

# Health History & Immunizations

This form must be completed and signed by your Healthcare Provider

## Personal Information

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

## Immunization History

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

### TB TESTS

**\*\*\* Skin Test or Chest X-Ray must be negative. No older than 6 months \*\*\***

#### TEST 1

Date \_\_\_\_\_ Measurement of induration in millimeters \_\_\_\_\_

Chest X-Ray Date \_\_\_\_\_

Current treatment for latent TB, please indicate medication dose, frequency and duration \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

#### TEST 2

Date \_\_\_\_\_ Measurement of induration in millimeters \_\_\_\_\_

Chest X-Ray Date \_\_\_\_\_

Current treatment for latent TB, please indicate medication dose, frequency and duration \_\_\_\_\_

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

### TETANUS/DIPHTHERIA/PERTUSIS (Tdap)

**\*\*\* No older than 10 years \*\*\***

Date \_\_\_\_\_

TD Date \_\_\_\_\_ \* If less than 2 years

### 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

**\*\*\* Complete Hepatitis B Declination Form OR have 3 immunizations OR Positive Titer \*\*\***

Hepatitis B Declination Form Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Immunization #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

Positive Titer Date \_\_\_\_\_

### VARICELLA

**\*\*\* Must have 1 of the following \*\*\***

Date of Disease \_\_\_\_\_

Date of Vaccine \_\_\_\_\_

Positive Titer Date \_\_\_\_\_

### INFLUENZA VACCINE

**\*\*\* Must have current season \*\*\***

Date of Vaccine \_\_\_\_\_

**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** \_\_\_\_\_

# Hepatitis B Declination Form

## *Student Statement concerning prior Hepatitis B immunization, Hepatitis B immunology, or Medical Contraindication*

I, \_\_\_\_\_ have been informed about the job classification exposure category for my course of study and I understand my risk category is category I.

Furthermore, I understand I do not need to have the Hepatitis B vaccination series to take this course.

\_\_\_\_\_ I have previously received the complete Hepatitis B vaccination series.

\_\_\_\_\_ Antibody testing has revealed that I am immune to Hepatitis B.

\_\_\_\_\_ For medical reasons, the Hepatitis B vaccine is contraindicated.

\_\_\_\_\_ I will pursue the vaccine later for employment.

I understand, however, if I have previously received the complete Hepatitis B vaccination series, but the US Public Health Service at a future date recommends a booster dose(s), such booster dose(s) will be made available to me upon request and free of charge so long as I am employed by the facility in a job classification that involved a risk of occupational exposure or some risk of occupational exposures to blood or other potentially infectious material.

If I have begun or completed the series, I will provide to the College of Continuing and Professional Education at KSU, medical documentation concerning my prior vaccination, immunity, or medical contraindication to Hepatitis B vaccine by within four weeks of the start date of the course.

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

# Application Packet Checklist

*Please return completed Application Packet to KSU. Incomplete packets will not be accepted.*

1. Have you completed the online **Skills Assessment & Program Application**?
2. Did you fill out the **Student Information**?
3. Did you read and fill out the bottom section of the **Release, Waiver of Liability & Covenant Not To Sue**?
4. Did you read, fill out, and sign the **Background Check Information**?
5. Did your Healthcare Provider fill out all sections of the **Health History & Immunizations**? If you have Titters, did you attach the values report?
6. Did you fill out the **Hepatitis B Declination** Form in lieu of immunizations or positive titers?
7. Did you make a copy of your **Driver's License**?
8. Did you make a copy of your **Social Security Card**?

END OF APPLICATION PACKET