Danville Area Community College

CERTIFIED NURSING ASSISTANT (CNA)
Application

This program is designed to prepare students to provide basic health care in hospitals and nursing homes. The program will provide training, experience, and educational opportunities that will benefit you and your community. To enroll in the program you must complete this application packet in its entirety.

_____ _____

Last Name **First Name**

_____

Street Address **City** **State** **Zip code**

(_____) _____ - _____

Area Code **Phone Number**

_____ _____

Email address DACC Student ID

CHECKLIST

☐ 1. Successful Completion of Health Occupations assessment or proof of successful completion of 8th grade or higher (high school transcripts or GED is adequate).

☐ 2.Applied to Danville Area Community College

☐ 3. Applied to the Certified Nursing Program including the following

- 2-Step Tuberculosis
- Physical – (Using form attached to application)
- Copy of Social Security Card
- Complete Healthcare Worker Background Check form
- Negative Drug Test – Drug test must be ordered using the following link. Drug Screen Link or you can request the link by emailing Nursing@dacc.edu

☐ 4. Schedule/completed Live fingerprint scan- https://flawlessbiometrics.com/schedule-fingerprinting/

Student Signature: _____ Date: _____

DANVILLE AREA COMMUNITY COLLEGE
CNA PROGRAM - HEALTH PHYSICAL FORM

To be filled out by the healthcare provider

Name (please print) _____
Last First Middle

Height _____ Weight_____BP_____ Pulse _____

	Normal	Abnormal	If abnormal, will it affect the student's ability to meet the technical standards as listed?
Appearance			
Head/neck			
Skin			
Ears			
Hearing			
Eyes			
Vision			
Nose			
Mouth/Teeth/Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Endocrine			
Neurological			

HEALTHCARE PROVIDER VERIFYING PHYSICAL EXAMINATION

The above individual was found free from symptoms of communicable disease, able to lift a minimum of 25lbs. unassisted, and otherwise physically and emotionally fit to perform the duties of a nursing assistant.

☐ Yes ☐ No

If no, please explain: _____

Name (Print) _____

Signature _____Date: _____

Updated May 2022

Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: (217) 785-5133

Health Care Worker Background Check

Disclosure and Authorization for Criminal History Records Check

I hereby authorize the Illinois Department of Public Health (IDPH), IDPH's designee that train or test health care workers, staffing agency, or the health care employer to request a criminal history records check and I further authorize the Illinois State Police (ISP) to release information relative to the existence or non existence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency which maintains records relating to me to provide same on request to the ISP or IDPH. I certify that the ISP and any agency, including IDPH, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or to retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment or, if discovered after employment begins, could result in discipline up to and including my termination of employment.

I understand that the information requested below regarding sex, race, height, eye color, and date of birth is for the sole purpose of identification and the gathering of the above-mentioned information about me accurately, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my social security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____

Physical Address if different _____

Other Names Used: _____ Telephone ____ - ____ - ____

States Where You Have Lived? _____

☐ Male ☐ Female Date of Birth _____ Height _____ Eye Color _____ Social Security Number ____ - ____ - ____

Race
- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undeterminable race. Of Untold mixture.
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect, or Theft? ☐ Yes ☐ No If "Yes", give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ■ No If "Yes", give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on IDPH's Health Care Worker Registry as a result of this criminal history records check:

_____ _____

(Signature) (Date)

As the parent or guardian of the above named individual, who is under the age of seventeen, I give my consent for this named individual to have a criminal history records check.

_____ _____

(Signature of Parent or Guardian when applicable) (Date)