Capital Area Career Center
Adult Certified Nursing Assistant (CNA) Class

- Our program is approved through the Illinois Department of Public Health.
- Registration is on a first-come, first-serve basis.
- The class fee is $950 due at the time of registration. Payments are accepted in cash, check, money order, or credit card. This fee covers tuition, textbook, background check, and CPR certification.
- Students must provide a High School diploma or GED.
- COVID vaccination is required for the clinical site. You must be fully vaccinated (2 weeks after the last vaccine) prior to clinical. **NO EXCEPTIONS**.
- Influenza vaccination is required.

Before the first day of class:

- Go to *The Firm, Inc.* at 6 Lawrence Square Springfield to get your background check. Their office hours are 9-4. Be sure to take your photo ID. The cost is $36.00 which is paid by the school.
- Get a 2-step TB skin test done. You may go to the Illinois Department of Public Health TB Clinic at 2833 South Grand Ave, Springfield. The cost is $30 which is paid by you. You may get the test done at your doctor's office. Bring the results to your first day of class.
- Obtain a 10-panel drug screen at Identi-check. The cost is $36.00 which is paid by you. **You must obtain authorization for results to be sent to the school.**
- Purchase your uniform consisting of royal blue scrub shirt and pants as well as white leather or vinyl tennis shoes. These are required to be worn for every class.

- Attendance is required at all classroom and clinical times.
- For successful completion: 77% in classroom, 77% on final exam, CPR certification, pass the 21 mandated skills, and pass the clinical rotation.
- Successful completion of this class qualifies the student to take the Illinois State CNA Competency examination.
- CNA state exam fee of $75.00 will be paid by you at the completion of the class.
- No refunds will be given once the class has started.
- Questions: Please call Amy@ 217-585-1215 (ext. 205).

Capital Area Career Center
2201 Toronto Road
Springfield IL 62712
Revised 7.30.2022

Capital Area Career Center

Adult CNA Registration Form

Class Start Date: ______________________________

Social Security Number: ______________________________

First Name: ______________________________

Middle Name: ______________________________

Last Name: ______________________________

Maiden Name: ______________________________

Gender: ______________________________

Birth Date: ______________________________

Place of Birth: ______________________________

Street Address: ______________________________

City: ______________________________

State: ______________________________

County: ______________________________

Zip Code: ______________________________

Country: ______________________________

Other States Lived In: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

ADULT CERTIFIED NURSING ASSISTANT PROGRAM
Authorization Notice for Drug Screening

My signature below authorizes ldenti-Check, or a facility of my choice, to send the results of the drug screening to Capital Area Career Center at the following address:

Capital Area Career Center
Attention: Adult CNA Program
2201 Toronto Road
Springfield, 11.62712
Phone: 217-585-1215 ext, 201
Fax: 217-525-2165

I have also read and understand the following: The fee is $36.00 paid by you.
I will call ldenti-Check 217-753-4311to schedule an appointment

For testing, I will go to:

Identi-Check
#3 North Old State Capitol Plaza,
Springfield, Illinois 62701

- Screening must be a 10-panelscreening, if not, CACC will refuse results.
- If a urine sample is too diluted, I must repeat the test at my own expense.
- I will provide picture identification at the time of the visit.

Testing must be completed within 15 business days of the date signed.

If you have any questions or concerns, please contact Amy.
Phone: 217-585-1215 ext. 205

______________________________ ____________________
Student Signature Date

HEALTH REQUIREMENTS FOR CLINICAL PARTICIPATION

Two-step TB Test

In order to screen for Tuberculosis, health care workers must have a test to determine if they are infected. Students may not participate in the BNAT program without these results. Call your health care provider immediately and tell them you need a 2-Step TB Test. The test may also be done at your local Public Health Department.

NOTE: It is very important to keep your appointments as you may have to start the entire process over.

Step 1

- Visit 1: Visit your health care provider and receive your 1st TB injection. It will appear that there is a small bubble of liquid under the skin of your inner forearm. Make an appointment to return for the reading of your first test.

- Visit 2: Return to your healthcare prover as scheduled for the reading of the test (48-72 hours). He or she will look for swelling, redness, or a raised area.

Step 2

- Visit 3: Day 7-14 Visit your healthcare provider as scheduled for the second injection

- Visit 4: Return to your health care provider as scheduled to get your test read (48-72 hours)

A negative two-step TB test indicates no current or previous TB injection. A positive two-step test indicates possible infection or exposure and additional evaluation is needed to rule out current TB infection.

Return to CASPN

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have 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, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, 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________ City________ State____ Zip Code________

Other Names Used________ Telephone________

States Where You Have Lived?________

○ Male ○ Female Race____ Height 5' , 0" " Weight____ lbs Date of Birth________ Social Security Number ☐☐☐-☐☐-☐☐☐☐
(Enter a letter from below)

Hair Color________ Eye Color________ City/State of Birth________

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.

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.

I certify that the above istrue and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

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

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

*** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED***

PRINT

CLEAR FORM

Adult CNA Student Checklist

Item	Date turned in:
Registration Form	
Copy of HS diploma or GED	
Background check form 1	
Background check form 2	
Drug screen authorization form	
Proof of TB	
Proof of COVID vaccination	
Proof of Flu vaccination	
Payments	

When you turn in your background check authorization form, you will receive a second7.30.22 Background release form. This second form **cannot** be emailed. You must pick it up in person at CACC or I can mail the form to you. Please let me know how you want to receive this second form. **Take the second form to The Firm for your background check.** When you have completed the background check, **the form needs to be returned back to us**. You may email this form to athompson@caspn.edu.