



Nightingale Healthcare Professionals

903 University Ave., Berkeley, CA 94710

☎ : 510.553.1800

☎ : 510.553.1818

✉ : training.nhp@gmail.com

🌐 : www.nhp.training

CERTIFIED HOME HEALTH AIDE (HHA) TRAINING PROGRAM REGISTRATION FORM

Name: _____

Driver License or State ID Number: _____ Issuing State: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____ CNA#: _____

Pronoun (circle one) she/her he/him them/they

Address: _____ City: _____

State: _____ Zip: _____ Cell Phone: () _____

Email Address: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Cell Phone: _____ Alternate: _____

Total Clock Hours of Instruction: 40 hours (20 hours theory & 20 hours clinical)

Upon successfully completing all requirements of the program, the student will receive a **Certificate of Completion** and a certificate for 26 Continuing Education Units.

Scheduled Start Date: _____ **Scheduled Completion Date:** _____

TRAINING FEES

Registration Fee (non-refundable) \$350.00

Home Health Aide Training Program Fee \$350.00

Total Training Cost \$700.00

Additional Student Responsibilities

- **SUBMIT** Negative COVID-19 results (results must be within 7 days of program start date) whether you are vaccinated or not you will still have to submit proof of testing within 7 days of first day of training.
- **Scrubs** of any color FOR CLINICAL ONLY

I hereby agree to fulfill all requirements for the 40-hour training; and confirm all the info I provided above to be correct to the best of my knowledge.

Applicant Signature X: _____ Date: _____

"Supporting the Future of Healthcare!"