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/non-transferable)	$350.00
Home Health Aide Training Program Fee	$350.00
Total Training Cost	$700.00

Additional Student Responsibilities

- **SUBMIT** physical photocopies of – valid physical, valid TB, proof of a negative Covid test dated within 7 days of training start date and a Student Clinical Log
- **Scrubs** of any color FOR CLINCAL 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: _____

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STUDENT CLINICAL LOG

The student has also successfully completed and submitted the following clearance documents

- Live Scan form BCIA 8016
- PPD dated within 3 months or a quantiferon blood test within 1 year or an X-ray completed in the past 3 years
- Physical completed within the past 6 months
- Flu shot during the time period, October 1st - March 31st

NAME _____

DOB (MM/DD/YYYY) _____

GENDER IDENTITY _____

COMPLETE ADDRESS _____

CELL PHONE _____

ETHNICITY

☐Blackamerican
☐Native American
☐Native Hawiian or Other Pacific Islander
☐White
☐Other (Include Ethnicty) _____

INSURANCE

Insurance Provider _____
Provider ID # _____
☐No Insurance

COVID VACCINATION STATUS

Brand _____

Dose Date _____

Dose Date _____

Dose Date _____

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MEDICAL EXAMINATION REPORT

STUDENT NAME:_____

S.S. #_____DATE OF BIRTH:_____

Please have the examiner fill out the information requested in each area. In some cases, only a MD may verify treatment of medical clearance to participate in the Nursing Program. Turn in completed form to NHP administrative office on the first day of class.

Please Circle: MALE FEMALE

Date of Examination: _____

HEIGHT:_____WEIGHT : _____

PULSE:_____/MIN RESP_____ BLOOD PRESSURE: _____

VISUAL ACUITY:
LENS: RT EYE:_LEFT EYE:_____

VISUAL ACUITY WITH CORRECTIVE
RT EYE:_____LEFT EYE:_____

CHECKLIST	NORMAL	ABNORMAL	DETAILED DESCRIPTION OF ABNORMAL FINDINGS
HANDS/SKIN			
HEAD EYES			
EAR/NOSE/THROAT/MOUTH			
NECK/NODES			
CHEST/LUNGS			
CARDIOVASCULAR			
ABDOMEN			
MUSCULOSKELETAL			
NERVOUS SYSTEM			

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STUDENT EXAMINATION OUTCOME

I hereby certify we have examined _____ and found them
(Student's Name)

S.S. #_____DATE OF BIRTH:_____

Cleared without limitation ☐ Yes ☐ No

Not cleared for this reason _____

_____

Physician's Printed Name: _____

Physician's Signature: _____
Address: _____
Telephone Number: _____

TB TEST Intradermal Skin Test (PPD Mantoux)

Date Tested _____ ☐ Negative ☐ Positive

If Positive skin test, a medical physician must enter in the following information:

Date of Chest X-ray:_____ (Within the Past Year) Result :_____

Chest X-ray and Questionnaire must be done annually ☐

Has this patient been prescribed any Chemotherapy to treat TB? _____

What medications are prescribed and what prescription/regimen? _____

Physician's Printed Name: _____

Physician's Signature: _____

Address: _____
Telephone Number: _____

Flu Shot (Flu Season October 1st – March 31st)

I have given _____ the _____
(Student's Name) (Flu shot Series)

PHYSICIAN'S SIGNATURE: _____

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ALL CLEARANCE FORMS MUST BE COMPLETED BEFORE ANY DIRECT PATIENT CONTACT

Please make arrangements to complete these requirements before the first day of class.
A COVID-19 Test, TB test, Livescan, Physical and Flu Shot (flu season: Oct 1st thru Mar 31st) are necessary to participate in clinical and will be required the first day of class. You cannot miss class hours to get tests completed. Please be advised these locations are here as an option, you may choose to accomplish these requirements at any location convenient and within your means.

COVID-19 TESTING

- *www.curative.com* Multiple Bay Area locations based on zip code
Cost: Free self-collected test (24-48 hour turn around on results)

TB TESTS AVAILABLE AT THIS LOCATION:

- *Berkeley Free Clinic:* 2339 Durant Avenue Berkeley, CA 94704
Cost: Free To schedule an appointment call (510) 548-2570 at 5:45 pm

- *Roots Community Health Center:* 9925 International Blvd #5 Oakland Ca 94603
Cost: $25 to schedule an appointment call 510.777.1177

COVID-19 Testing
Cost: Free To schedule an appointment visit https://rootsclinic.org/covid-19-testing/

LIVESCAN AND PHYSICALS AVAILABLE AT THIS LOCATION:

For a list of more local vendors visit https://oag.ca.gov/fingerprints/locations
(OCA Number is your Social Security Number)

Checkpoint OTC
1 Market St Oakland, Ca 94607
(510) 836-0448

No appointment needed
Livescan $57 Open Monday – Friday
Physical $70 Open Monday – Friday

PHYSICAL, TB TEST AND FLU SHOTS AVAILABLE AT THIS LOCATION:

Open Mon – Fri 8:30am - 3:30pm No appointment needed

Dr. Konstantin
2584 MacArthur Blvd.
Oakland, CA 94602
(510) 530-5400

$40 instant COVID-19 Test
$70 for all 3 (best value)
$30 TB test only
$50 Physical only

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