



GateWay Community College

NURSING ASSISTANT PROGRAM

**Information Packet for classes beginning
January 2010 through August 2010**

GateWay Community College

NA/PCT/BNFP Coordinator: Kathy Prioreshi, RN, BSN, 602-286-8535

Director, Nursing Division: Margi Schultz, PhD, RN, 602-286-8530

fax: (602) 286-8478



NURSING ASSISTANT PROGRAM

Course Information

Upon satisfactory completion of the Nursing Assistant Course (NUR158), the student is eligible to receive a certificate of completion from the college. Each student must apply for the certificate of completion by the specific date of graduation checkout, approximately 6-8 weeks before the end of the program (Refer to the Course Schedule).

Occupational Information

Nursing Assistants perform routine tasks in the general care of hospital, clinic, and nursing home patients. They work directly under the supervision of registered and practical nurses. Their role in performing basic patient care assists the licensed staff in providing quality nursing to the patient. The Nursing Assistant occupation is one of a series of possible steps on a career ladder in the health care field. Nursing Assistants are an important member of a health care team. Typical patient-care duties include bathing and dressing patients, helping with personal hygiene, taking vital signs, answering call lights, transporting patients, servicing and collecting food trays, and feeding patients.

Certification Information

The Maricopa Community Colleges offer a comprehensive Nursing Assistant Course that is approved by the Arizona State Board of Nursing. Upon satisfactory completion of this course, the student is eligible to take the Arizona State Board of Nursing certifying exam, become a Certified Nursing Assistant, and choose to go directly to work or continue to pursue education opportunities in other health care careers.

Information on the Arizona State Board of Nursing application process is available at <http://www.azbn.gov>. The certifying exam is administered by state certified evaluators and students may take the exam scheduled at nearby testing centers. The fee for this exam is \$85 (subject to change) and is payable to the state evaluators.

An additional and separate Fingerprint Clearance Card is required for certification. The Department of Public Safety card required for enrollment in nursing classes at the colleges will not meet the requirements for state certification. Allow a minimum of six (6) weeks for fingerprint clearance when applying for nursing assistant certification.

The Arizona State Board of Nursing office is located at 4707 North 7th Street, Suite 200, Phoenix, Arizona, 85014-3653. Phone 602.889.5150, FAX 602.889.5155. <http://www.azbn.gov>

Cost Estimate for the Nursing Assistant Program *

Registration Fee/Course Fee		40.00
NUR158 Nursing Assistant Courses, 6 credits (Maricopa County Resident)		426.00
Fingerprinting fee	Cost will Vary	50.00
Textbooks	Approx.	90.00
Urine Drug Screen		73.00
Uniform and Clinical Supplies	Cost will Vary	80.00
Physical Exam and Immunizations	Cost will Vary	225.00
Total Estimated Cost of Nursing Assistant Program		\$984.00

*Fees are subject to change by the Maricopa Community Colleges Governing Board. All costs quoted are subject to change



NURSING ASSISTANT PROGRAM

INFORMATION FOR STUDENTS

- **ZERO TOLERANCE POLICY:** The Maricopa Community Colleges Nursing Assistant Program supports a Zero Tolerance Policy for the following behaviors:
 - Intentionally or recklessly causing physical harm to any person on the campus or at a clinical site, or intentionally or recklessly causing reasonable apprehension of such harm.
 - Unauthorized use or possession of any weapon or explosive device on the campus or at a clinical site.
 - Unauthorized use, distribution, or possession for purposes of distribution of any controlled substance or illegal drug on the campus or at a clinical site.Nursing Program student engaging in this misconduct is subject to immediate dismissal from nursing classes and disciplinary action as described in the Student Handbook of the college.

- **HEALTH DECLARATION:** It is essential that nursing students be able to perform a number of physical activities in the clinical portion of the program. At a minimum, students will be required to lift patients, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement direct patient care. The clinical nursing experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions. Individuals should give careful consideration to the mental and physical demands of the program prior to making application.

All students placed in the nursing program must provide documentation of compliance of all health and safety requirements required to protect patient safety. Only students providing documentation of compliance are permitted to enroll in nursing courses. Students will meet these requirements by providing the Health/Safety Requirements Documentation Checklist and the signed Health Declaration Form, with all documentation attached, as directed.

- **FINGERPRINTING REQUIREMENT:** Fingerprint clearance is required for enrollment in nursing courses. Fingerprint clearance is required to work and care for children, the elderly, and any vulnerable adult. If there is a positive criminal history, a fingerprint clearance may be denied. The Fingerprint Clearance Card cannot expire during the Nursing Assistant program. The Fingerprint Clearance Card required for the Nursing Assistant program will not meet the requirements for certification through the Arizona State Board of Nursing.

- **DRUG SCREENING:** All students are required to submit to a urine drug screening laboratory test. Students must complete the urine drug screening under the program account number, within the specified timeframe, and according to directions given at the time of notification to meet this requirement. Only students meeting the drug screening requirement and receiving negative drug screens, as reported by the Medical Review Officer (MRO), will be permitted to maintain enrollment in nursing courses.

- **WAIVER OF LICENSURE/CERTIFICATION GUARANTEE:** Admission or graduation from the Nursing Program does not guarantee obtaining a license or certificate to practice nursing. Licensure and certification requirements and the subsequent procedures are the exclusive right and responsibility of the Arizona State Board of Nursing. Students must satisfy the requirements of the Nurse Practice Act: Statutes, Rules and Regulations, independently of any college or school requirements for graduation.

According to A.R.S. § 32-1646 (B), an applicant for nursing assistant certification is not eligible for certification if the applicant has had any felony convictions and has not received an absolute discharge from the sentences for all felony convictions. The absolute discharge from the sentence for all felony convictions must be received five (5) or more years before submitting this application. If you cannot prove that the absolute discharge date is five or more years, the Board will notify you that you do not meet the requirements for certification.

All nursing assistant applicants for certification will be fingerprinted to permit the Department of Public Safety to obtain state and federal criminal history information. All applicants with a positive history are investigated. If there is any question about eligibility for licensure or certification, contact the nursing education consultant at the Arizona State Board of Nursing (602-889-5150).



NURSING ASSISTANT PROGRAM

REQUIRED INFORMATION

(PRINT) Name _____ Student ID Number _____

Phone: Day _____ Evening _____ Cell _____

Mailing Address _____

City _____ State _____ Zip _____

(PRINT) E-Mail Address _____

E-mail will be used to contact you about registration for classes.

DIRECTIONS:

You must complete a Student Information Form for GateWay, either online at www.gatewaycc.edu or in person at the Admissions and Records office.

- Review application form with a nursing advisor at GWCC. Completed applications directed to Kathy Prioreshi, RN:
 - the Health and Safety Documentation Checklist and
 - Health Care Provider Signature Form with all documentation attached,
 - a copy of the front and back of the Fingerprint Clearance Card,
 - a copy of the front and back of the Health Care Provider CPR card.
- Verify that all Health and Safety Requirements remain current through the last day of the Nursing Assistant course.
- Return this form and all documentation for the Health and Safety Requirements to Kathy Prioreshi at GWCC.
- Only students with complete documentation of health and safety requirements will receive permission to register for the nursing assistant course.



NURSING ASSISTANT PROGRAM

Nursing Department Check of Registration Requirements

Name: _____ Date _____ Nursing Staff Initials _____

Requirement	Check	Notes
Health Care Provider form		
Fingerprint Card		
Health Care Provider CPR card		
Td		
MMR x 2/ Titer	MMR _____ Rubeo ___ Mumps ___ Rub _____	
Varicella x 2/ Titer		
HBP x3/ titer		
Two- StepTB skin test Chest X-ray		
Recommendation for Registration		



**MARICOPA COMMUNITY COLLEGE DISTRICT NURSING PROGRAM
HEALTH AND SAFETY DOCUMENTATION CHECKLIST**

Applicant: _____ Student ID _____ Date: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

A. MMR (Measles/Rubeola, Mumps, Rubella): Requires documented proof of two MMRs in lifetime or a positive titer for each of these diseases.

1st MMR Date: _____ 2nd MMR Date: _____

OR

Date & results of titer: Measles/Rubeola _____ Mumps _____ Rubella _____

Circle: Yes or No I have attached documented proof as specified above.

B. Varicella (Chickenpox): Requires documented proof of two (2) vaccinations or positive IgG titer.

1st Varicella Date: _____ 2nd Varicella Date: _____ **OR** Date & results of IgG titer: _____

Circle: Yes or No I have attached documented proof as specified above.

C. Tetanus/Diphtheria (Td) immunization within the past 10 years. Td Date: _____

Circle: Yes or No I have attached documented proof as specified above.

D. Tuberculosis: Documentation of an initial **Two-Step TB skin test** (PPD) and annual Update of TB skin test. If positive skin test, provide documentation of chest X-ray within the last 2 years, and annual documentation of a TB disease free status. **All skin testing must have been completed within the previous six (6) months.**

Initial Test: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive **AND**

2nd Step Test: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive **OR**

Annual Update: Date: _____ Date of Reading: _____ Results (circle): Negative **OR** Positive **OR**

Chest x-ray Date: _____ Results: _____ Date of Symptom Sheet _____

Circle: Yes or No I have attached documented proof as specified above.

E. Hepatitis B: Documented evidence of completed series or positive antibody titer. If beginning series, first injection must be prior to admission, the second in one month and third in 6 months.

Date of 1st injection: _____ **OR** Hep B Titer Date: _____

Date of 2nd injection: _____ Titer Results: _____

Date of 3rd injection: _____ **OR** HBV Vaccination Declination Form Date: _____

Circle: Yes or No I have attached documented proof as specified above.

F. Health Care Provider CPR Card: Date CPR card Issued: _____ Expiration Date: _____

Circle: Yes or No I have attached a copy of both sides of the CPR Card. CPR certification must remain current through the semester of enrollment.

G. Fingerprint Clearance Card: Date Card Issued: _____ Expiration Date: _____

Circle: Yes or No I have attached a copy of both sides of the Fingerprint Clearance Card current through the semester of enrollment.



Health Care Provider Signature Form

Instructions for Completion of Health Care Provider Signature Form

A health care provider **must** sign Health Care Provider Signature Form **within 12 months of application** and indicate whether the applicant will be able to function as a nursing student. Health care providers who qualify to sign this declaration include a licensed physician (M.D., D.O.), a nurse practitioner, or physician’s assistant.

(Please Print)

Applicant Name _____ Student ID Number _____

It is essential that nursing students be able to perform a number of physical activities in the clinical portion of the program. At a minimum, students will be required to lift patients, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement direct patient care. The clinical nursing experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients’ lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions. Individuals should give careful consideration to the mental and physical demands of the program prior to making application.

I believe the applicant _____ WILL OR _____ WILL NOT be able to function as a nursing student as described above.

If not, explain: _____

Licensed Healthcare Examiner (M.D., D.O., N.P., P.A.)

Print Name: _____ Title: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: _____

Phone: _____



MARICOPA COMMUNITY COLLEGE DISTRICT NURSING PROGRAM

INSTRUCTIONS FOR COMPLETING HEALTH AND SAFETY FORMS

IMPORTANT: All students placed in the MCCDNP must provide documentation of compliance for the vaccinations and TB testing required to protect patient safety. Only students providing documentation of health and safety requirements are enrolled in nursing courses. The Nursing Department will accept only photocopies of all documentation of health related materials. Students are responsible for maintaining their records and must submit documentation when due. All immunization records must include your name and signature of the healthcare provider. A health care provider's signature on the Health Declaration form, without proof of immunization status, is NOT acceptable.

REQUIREMENTS

A. MMR (measles/rubeola, mumps, rubella)

Options to meet this requirement:

- a. Attach a copy of proof of two previous MMR vaccinations to the health declaration form.

OR

- b. If you had all three illnesses OR you have received the vaccinations but have no documented proof, you must have a titer drawn for each illness.
1. If the titer results are POSITIVE, attach a copy of the results to the health declaration form.
 2. If the titer results are NEGATIVE, you must get your first MMR vaccination and attach documentation to the health declaration form. The second MMR must be completed within one month and proof submitted to the nursing department.

B. Varicella (chickenpox)

Options to meet this requirement:

- a. Attach a copy of proof of a positive IgG titer for varicella.

OR

- b. If the titer is NEGATIVE, attach a copy of proof to the health declaration form that you received the first vaccination. Complete the second vaccination in 4 to 8 weeks and submit proof to the nursing department.

C. Tetanus/Diphtheria (Td) immunization within the past 10 years. Attach a copy of proof of Td vaccination.

D. Tuberculosis (TB)

- a. Attach a copy of proof of Two-Step TB skin test (PPD). Documentation for TB skin testing requires date, and name and signature of the healthcare provider.

OR

- b. If positive skin test, provide documentation of chest X-ray within the last 2 years and annual documentation of a TB disease free status by completing the Tuberculosis Screening Questionnaire.

E. Hepatitis B

If you have not received the injections in the past, do not test for titer. You must obtain the first injection and attach a copy of proof of the injection to the health declaration form. You must receive the 2nd injection in one month and the 3rd five months after the second. Submit documentation to the nursing department.

- a. Attach a copy of proof of completion of three Hepatitis B injections to the health declaration form.

OR

- b. If received entire series, attach a copy of proof of a positive HbsAB antibody titer to the health declaration form.

OR

- a. Signed Hepatitis B Virus (HBV) Vaccination Declination Form

F. CPR Card:

Attach a copy of both sides of the Health Care Provider CPR card to this form. CRP certification must include infant, child, and adult, 1 and 2 man rescuer, and evidence of a land-based demonstration component. **CPR certification** must remain current through the semester of enrollment. Please sign the back of the card.

G. Fingerprint Clearance Card:

Attach a copy of the front and back of the Fingerprint Clearance Card. The Fingerprint Clearance Card must remain current through the semester of enrollment.