Continuing Education Application

Medication Aide Program (NURA 1013)

Semester Requested *(Check one)*: ☐ Fall ☐ Spring ☐ Summer Year: _______

Access to Austin Community College's programs or activities shall not be limited on the basis of race, color, creed, national origin, religion, age, gender, sexual orientation, political affiliation, or physical disability. Applications accepted year round.

Please Type or Clearly Print Date of Birth ____/____/____

ACC Student ID: ____________________ e-mail address: ______________________________________
Leave blank if you do not have one

Name: ____
Last *First* *Middle*

Home Address: ____
Number & Street *County* *City* *State* *Zip*

Home Phone: _______________ Alternate Phone: _________________ Social Security No. ____________

Please Complete: (for State Reporting Purposes only)

Ethnicity/Race: Hispanic/Latino Black/African American Asian White American Indian/Alaskan Native Native Hawaiian/Pacific Islander Other

Gender: Female Male

All students who enter the clinical setting (i.e. clinic, hospital, other) must meet "Community Standards" concerning **criminal background** screening and state **vaccination** requirements. Vaccinations can take from 4-6 months to complete, so students are urged to plan accordingly. Additional information about the Medication Aide Certificate is available at www.austincc.edu/ce/hpi.

It is the student's responsibility to:

Return this application to the Medication Aide Program Coordinator, ACC Highland Business Center (HBC), 5930 Middle Fiskville Road, Austin, Texas, 78752 with immunizations and background check completed, and all required documentation enclosed for review and approval prior to registering for the course. For assistance, please email eahuss@austincc.edu.

For Continuing Education Office Use Only

☐ Accepted ☐ Rejected

Application Received – Date: ______________
Added/Verified to Datatel – Date: ______________
Petitioned – Date: ______________

Reviewed By:

________________________________ Date: ______________
Print Name and Phone Extension

Student Advised of Status – Date: ______________ ☐ by email ☐ by mail ☐ by phone ☐ by message ☐ in person

Updated: 9/21/2009

EMPLOYMENT. *Employment required in a state approved LTC, MHMR, or AL facility on the first official day of class.*

Place of Employment: ____ Phone: __________________

Type of Facility: ____ Date of Hire: _____________________

Job Title: ___________________________ Nurse Aide Certificate Number (if applicable) ________________

Type of Work Performed (be specific) ____

EDUCATION. *Texas Department of Aging & Disability Services requires proof of completion of high school or equivalent GED for certification.* **All applicants must provide one (1) copy:**

☐ GED ☐ High School Diploma

Country of Origin _____________ Primary Language ____________________

Must be able to read and write English. If diploma or GED is issued from a non-English speaking country, you must show a passing score on appropriate English as a Second Language Assessment or comparable assessment. Testing may be arranged at the Assessment Center: (512) 223-3139.

ESL Assessment: ☐ Yes ☐ No Reading Score: ______ Writing & Grammar Score:________ Oral: ______

Compass or TASP: ☐ Yes ☐ No Location: ______________________ Date: _____________________

Important: Documentation of immunizations ARE required at the time of application (see "Immunizations, Tests, and Background Check Required by State Law/Clinical Facilities" form). Program applications are NOT accepted without completed immunization documentation. Vaccines administered on or after September 1, 1991 must include the mm/dd/yy each vaccine was given. Physician-documented history of disease and serum titers must be the date of diagnosis or test collection, not when form was signed by health care provider.

Application Checklist:

______ Completion of **"Immunizations"** form (attached)
______ Submission of criminal background check to PreCheck.com
______ Copy of high school diploma or GED certificate
______ Copy of relevant ESL, Compass, or TASP Scores if diploma or GED certificate was issued in a non-English-speaking country

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Acceptance of an application does not guarantee a student a seat in the course. Students must complete an application before registering. Classes may fill quickly, preventing a student from registering even though the student has completed the accepted application on file with the continuing education department. Students must notify the Health Professions Institute for Continuing Education of any change in applicant data. Failure to do so may result in the withdrawal of permission to register in the classes or the inactivation of the application.

I hereby certify that the information contained in this application is true and complete to the best of my knowledge. I understand that any misrepresentation or falsification of information is cause for denial of admission or expulsion from the College. I understand that the faculty and staff of the Health Professions Institute for Continuing Education will read the information contained in this application.

____ ____________________

Signature of Applicant Date

AUSTIN COMMUNITY COLLEGE DISTRICT

Immunizations, Tests, and Background Check Required by State Law/Clinical Facilities

Name: ______________________ **SSN or ACC ID#:** ______________________

Program: ______________________ **Date of Birth:** ______________________

Criminal Background Check Please indicate the date you submitted your request to www.precheck.com for PreCheck to conduct the background check.	Date ______________________ (mm/dd/yy)

Measles (Rubeola). Those born on or after January 1, 1957++ must show proof of either:	
A. **Two** doses of measles vaccine on or after their first birthday and at least 30 days apart **OR** ***See note.**	Date #1 __________ (mm/dd/yy) Date #2 __________ (mm/dd/yy)
B. Record of physician-diagnosed measles **OR** ****See note.**	Date ______________________ (mm/dd/yy)
C. Serologic test positive for measles antibody ****See note.**	Date __________ (mm/dd/yy) Result __________
Mumps. Those born on or after January 1, 1957++, must show proof of either:	
A. One dose of mumps vaccine on or after their first birthday **OR**	Date ______________________ (mm/dd/yy)
B. Record of physician-diagnosed mumps **OR** ****See note.**	Date ______________________ (mm/dd/yy)
C. Serologic test positive for mumps antibody ****See note.**	Date __________ (mm/dd/yy) Result __________
Rubella. ALL students must show proof of either: **NEW REQUIREMENT**	
A. One dose of Rubella vaccine on or after their first birthday **OR**	Date ______________________ (mm/dd/yy)
B. Record of physician-diagnosed Rubella **OR** ****See note.**	Date ______________________ (mm/dd/yy)
C. Serologic test positive for Rubella antibody ****See note.**	Date __________ (mm/dd/yy) Result __________
Hepatitis B. Must show proof of:	

A. Three doses of vaccine administered over a period of 4-6 months. The second dose of the vaccine must be at least 4 weeks after the initial dose. The third dose must be given at least 12 weeks after the second dose. **OR**	Date #1 ____________ (mm/dd/yy) Date #2 ____________ (mm/dd/yy) Date #3 ____________ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody ****See note.**	Date ____________ (mm/dd/yy) Result ____________

Varicella. Must show proof of:	
A. **Two** doses of Varicella vaccine administered 4-8 weeks apart **OR**	Date #1 ____________ (mm/dd/yy) Date #2 ____________ (mm/dd/yy)
B. Serologic test positive for Varicella antibody **OR** ****See note.**	Date ____________ (mm/dd/yy) Results ____________
C. Physician documented history or diagnosis of Varicella ****See note.**	Date Disease Occurred ____________ (mm/dd/yy) Documented history after September 1, 1991 must have a month, day and year.
***Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13).**	

Diphtheria, Tetanus (Td) One dose within past 10 years at the time of application	Date ____________ (mm/dd/yy)
Tuberculosis Test (PPD) Tuberculosis Skin Test (PPD skin test or chest x-ray) with a negative reading is required with the submission of application. (Test may not be more than 180 days old on the first day of class.)	Date ____________ (mm/dd/yy) Results ____________

*** Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**
**** Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**
+ Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given.
++ To be exempt from proof of measles and/or mumps, those born before January 1, 1957 must provide copy of photo ID.

Physician or Approved Licensed Health Professional Information:	
Printed Name	
Address	
Signature of Primary Care Provider (only validates vaccination & PPD info above)	Date

Updated: 9/21/2009