

**Med-Cert Training Center – Maple Heights**  
**5416 Northfield Road**  
**Maple Heights, OH 44137**  
**Phone (440) 786-2378, Fax (440) 786-7327**  
**Email:medcertraining@yahoo.com**

**Med-Cert Training Center – AKRON**  
**771 North Main Street**  
**Akron, OH 44310**  
**1-877-514-2378**  
**Email:medcertraining@yahoo.com**

## Application for Admission Nurse Aide Training Program

Interested in taking classes at this location:    † Maple Heights    † Akron

How did you hear about us?            † Web   † Friend   † Radio   † Other \_\_\_\_\_

I plan to enroll in the class scheduled for the month of \_\_\_\_\_

Check one of the following:   † Day (Mon/Wed)   † Day (2 Week)   † Evening   † Weekend

Full Name _____				
Last	First	Middle		
Mailing Address _____				
Street	City	State	Zip	
Home Telephone Number _____		Social Security # _____		
Cell Number _____		Email Address _____		
Date of Birth _____				
In Case of Emergency Notify _____		Phone Number _____		

**Education History:** List High School, College or other schools attended including other Nurse Aide Training Programs

School	Address	Years Attended (mm-yy) / (mm-yy)	Area of Study	Highest Level Completed	Did You Graduate?

**Employment History:** List your two most recent positions.

Date (month and year)	Employer	Salary	Position	Reason for Leaving
From:				
To:				
From:				
To:				

**\*\*\*IMPORTANT INFORMATION\*\*\***

**Physical and 2-Step TB Test**

Completed physical form **and** evidence of 2-step TB test **must** be submitted to Med-Cert by the second Monday of the 2 week class and by the beginning of the third week for all other classes.

**Signature:** \_\_\_\_\_

**Criminal Background Check**

Complete background check **must** be submitted to Med-Cert by the second Monday of the 2 week class and by the beginning of the third week for all other classes.

I swear and affirm that I have not committed or have been convicted of a violent crime, theft, or exploitation of the elderly. **I understand that Senate Bill 160 will not permit individuals with certain misdemeanors and felonies to work in Long-Term Care Facilities.**

**Signature:** \_\_\_\_\_

**By signing below, I verify that the information I have supplied in this document is true and complete to the best of my knowledge, and that I have read Med-Cert Training Center's General Information and Policies.**

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

**For Med-Cert Use Only:**

Tuition Amount Paid \$ \_\_\_\_\_

T-Shirt Amount Paid \$ \_\_\_\_\_

Background Check Amount Paid \$ \_\_\_\_\_

**TOTAL AMOUNT PAID \$ \_\_\_\_\_**

Payment information: † Cash    † Check or Money Order # \_\_\_\_\_    † Credit Card

Received by \_\_\_\_\_ Date: \_\_\_\_\_

† TB Test Attached    † Physical form Attached    † Background Check Attached

# Med-Cert Training Center

## Refund/Transfer Policy

### Refund Policy:

**No refunds** will be made to students who withdraw from classes regardless of reason for withdrawal. All monies paid to hold your place in class are non-refundable. **When you reserve space in a class, others may have been denied placement in the training program due to lack of space.** Enrollment is on a first come first serve voluntary basis. As a result, once you reserve a spot in a class the monies paid cannot be refunded. You will not be held responsible for any unpaid balance and will not be billed.

### Transfer Policy:

If you need to transfer from a class, please let us know at least two full business days in advance so that we may fill your space. Please be sure to call during regular business hours (Monday through Friday, 09:00AM - 06:00 PM, excluding major holidays). A \$15.00 processing fee will be assessed for all transfer requests. A re-registration fee of \$100.00 will be assessed if you cancel within 2 business days of the start of the scheduled class.

If a student starts a class and decides that he/she wants to transfer after the class start date the student will be assessed a \$150.00 transfer fee. **All transfer requests after the start of class must be received in writing.**

<b><i>Transfer Request Received:</i></b>	<b><i>Transfer Fee:</i></b>
3 or more days before first day of class	\$15.00
1 to 2 days before the first day of class	\$100.00
First day of class or later	\$150.00

By signing below I agree to, understand and accept the above policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
For Med-Cert use only:

Date of withdrawal \_\_\_\_\_

Withdrawn by \_\_\_\_\_

Revised May 10, 2011

**Med-Cert Training Center**  
**20 West Grace Street, Suite D, Bedford, OH 44146**  
**Phone (440) 786-2378 / Fax (440) 786-7327**

**STUDENT HEALTH FORM**

Name	Class enrolling in:
Address	Month _____ Day _____ Year _____
Phone Number	Circle one: Mon/Wed    2-Week    Evening    Weekend

**Requirements for Clinical Participation**

(Both the section for TB Test and Verification of health must be completed)

## 2-Step TB Test

2-Step TB testing is required to participate in clinical practice. Please record the results below.

Test #	Date Given	Forearm site	Given By	Date Read	Results	Read By
#1		R or L			_____mm	
#2		R or L			_____mm	

If a positive skin test reaction is noted and a chest x-ray is required a copy of the x-ray results must accompany this form.

Comments:

\_\_\_\_\_  
Signature/Title/Agency (*where TB Test was done*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Phone

## Physical Exam

Each student participating in the nursing assistant/home health aide training program is required to successfully pass a complete physical examination and be certified as physically fit to participate.

*After review of the above named individual's medical history I certify that he/she is able to fully participate in the nursing assistant/home health aide training program without restriction. Please comment below if restrictions are recommended.*

**Check One:**    ☐ **Full Participation**

☐ **Cannot Participate**

Comments:

\_\_\_\_\_  
Signature/Title/Agency

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Phone

*Med-Cert Training Center*  
*20 West Grace Street, Suite D*  
*Bedford, OH 44146*  
*Phone (440) 786-2378, Fax (440) 786-7327*  
*Email:medcerttraining@yahoo.com*

## **State Tested Nurse Aide (STNA) Training Program**

### **Overview & General Information**

#### **Course Description**

A 76-hour State approved course covering Basic Nursing Skills, Personal Care Skills, Mental Health, and Social Service Needs. Basic Restorative Services, Residents' Rights, Communication and Interpersonal Skills, Infection Prevention and Control, Safety and Emergency Procedures, Promoting Residents Independence and Respecting Resident's Rights. To receive a Certificate of Successful Completion student must pass written exams with an overall score of 80% or greater and demonstrate proficiency in all skills learned. Student must also complete 16 hours of mandatory hands-on clinical.

#### **Admission Guidelines**

Diploma or GED is not required, but candidate must be able to read and perform basic math skills. Student must be at least 16 years old to begin training. Good physical health exam, 2-step TB tests and background check **must** be submitted to Med-Cert by the second Monday of the 2 week class and by the beginning of the third week for all other classes.

#### **The Role of the Nurse Aide**

The Nurse Aide is an important member of the nursing team. This individual is instrumental in providing residents with basic nursing and personal care, as well as providing emotional and physical support

#### **Employers**

There is a high demand for State tested Nurse Assistants in Nursing Homes, Hospitals, Home Health Care, Hospice and Assisted Living Facilities.

#### **NOTE**

We train students with the information that is required to take the Ohio Department of Health's Nurse Aide competency test, a multiple choice written/oral test and skills test to become a State-Tested Nurse Aide (STNA). The State Exam is scheduled after the completion of classes & Clinicals.

The training received at Med-Cert will fully prepare students to take the state exam. We encourage all of the students to take the exam as soon as possible after completing the training curriculum.

#### **STATE REQUIREMENTS**

- Course length is 60 hours of classroom training plus 16 hours of clinical training.
- See attached calendars for class times and dates.
- Clinicals — The State of Ohio mandates at least 16 hours of clinical training. Failure to attend all 16 hours (due to absence or tardiness) will result in an incomplete. Training must be completed within 60 days of the last day of your program. Make-up training will be completed based on space and availability in the next scheduled class.

## **UNIFORM REQUIREMENT**

- *S.T.N.A. Class* – Any classroom **appropriate** clothing can be worn.
- *CLINICAL* – Green Med-Cert Trainee T-shirt (purchased through Med-Cert for \$11.00 (\$15.00 sizes 2XL and 3XL), WHITE Scrub Pants and SHOES (No exceptions)
- *NAME BADGE* – provided by Med-Cert

## **ATTENDANCE - NO EXCEPTIONS**

- **DUE TO THE LENGTH OF THE PROGRAM ABSENCE FROM CLASS IS STRONGLY DISCOURAGED.**
- THERE IS ONLY ONE (1) MAKE-UP DAY!
- CLINICALS CANNOT BE MADE-UP!
- S.T.N.A. TRAINEE'S ARE ALSO GRADED FOR PUNCTUALITY!
- IF LATE FOR CLINICAL STUDENT IS NOT ALLOWED OR ADMITTED ON FACILITY FLOOR!

## **CELL PHONES PROHIBITED**

- CELL PHONES ARE TO BE TURNED OFF PRIOR TO CLASS & CLINICALS! (NO RINGING - NO VIBRATING - NO BEEPING - NO TEXTING)!
- Telephones may ONLY be used during your 15-minute break or scheduled lunch time!

## **STATE REQUIREMENTS**

- Course length for the Weekend Class is 5 weekends (9:00am - 5:30pm, Saturday, and Sunday) for a total of 60 hours of classroom training plus 16 hours of clinical training.
- Course length for the Day Class is 6 weeks (Monday and Wednesday from 8am-2:30pm) for a total of 60 hours of classroom training plus 16 hours of clinical training.
- Course length for the Evening Class is 5 weeks (Monday – Thursday from 5:30pm-9:45pm) for a total of 60 hours of classroom training plus 16 hours of clinical training.
- Course length for the 2 Week Day Class is 2 weeks (Monday-Friday from 8:00am-4:30pm) for a total of 60 hours of classroom training plus 16 hours of clinical training.
- Our next scheduled Weekend class starts \_\_\_\_\_.
- Our next scheduled Evening class starts \_\_\_\_\_.
- Our next scheduled Day class (Mon/Wed) starts \_\_\_\_\_.
- Our next scheduled 2 Week Day class (Mon-Fri) starts \_\_\_\_\_.
- Clinicals — The State of Ohio mandates at least 16 hours of clinical training. Failure to attend all 16 hours (due to absence or tardiness) will result in an incomplete. Training must be completed within 60 days of the last day of your program. Make-up training will be completed based on space and availability in the next scheduled class.

**MED-CERT TRAINING CENTER  
AUTHORIZATION TO RELEASE INFORMATION FORM**

**Note: Submitting an incomplete or illegible form may delay the background check results.**

I hereby AUTHORIZE and request any law enforcement agency to furnish bearer with criminal history and identity check information in their possession regarding me in connection with my employment in a critical position. I am willing that a photocopy of this authorization be accepted with the same authority as the original. I understand this AUTHORIZATION is to be part of the written employment application which I sign. I understand that Bradco Environmental positions that are designated critical require background checks for the purpose of evaluating me for employment, promotion, reassignment, reclassification, transfer, or retention as an employee. I also understand that any misrepresentation, falsification or omission of facts herein may be grounds for disqualification, release or dismissal.

***Class enrolling in (if applicable):*** month \_\_\_\_\_ ↑ ***Mon/Wed*** ↑ ***2-Week*** ↑ ***Weekend*** ↑ ***Evening*** ↑ ***Other***

**PRINT NAME:** \_\_\_\_\_  
Last First Middle

**Current Address:** \_\_\_\_\_  
Street Number & Name City State Zip How Long?

**DATE OF BIRTH:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_  
**HOME PHONE #:** \_\_\_\_\_ **CELL PHONE #:** \_\_\_\_\_

**OTHER NAMES YOU HAVE USED:** \_\_\_\_\_

***Have you been background checked at Med-Cert Training Center previously?*** ☐ YES ☐ NO

***If yes, please note date (approximate):*** \_\_\_\_\_

**SINCE YOUR 18<sup>TH</sup> BIRTHDAY, HAVE YOU BEEN CONVICTED OF A FELONY OR FELONY-REDUCED-TO MISDEMEANOR CONVICTION BY ANY COURT? YOU MAY OMIT CONVICTION OF A MISDEMEANOR WHILE UNDER AGE 18 IF THE RECORD WAS SEALED UNDER PENAL CODE 1203.45, MINOR TRAFFIC VIOLATIONS FOR WHICH THE FINE IMPOSED WAS \$400.00 OR LESS, ANY OFFENSE THAT WAS FINALLY SETTLED IN JUVENILE COURT OR REFERRED TO THE YOUTH AUTHORITY, OR ANY CONVICTION SPECIFIED IN HEALTH AND SAFETY CODE SECTION 11361.5 WHICH PERTAINS TO CERTAIN MARIJUANA OFFENSES.** ☐ YES ☐ NO

***If yes, please indicate date, location and explanation:***

---

---

---

---

**DRIVER'S LICENSE  
INFORMATION:**

\_\_\_\_\_  
License number Expiration Date State of Issue

I hereby certify that all statements on this application are true and correct to the best of my knowledge and belief. I understand that Med-Cert solicits this information so as to be informed of my previous record and character. I understand that my enrollment with Med-Cert depends upon successful completion of a criminal background investigation. I understand that any falsification, misrepresentation or omission of facts of this record may be considered cause for release or dismissal.

**APPLICANT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Med-Cert now offers a background check service. For \$15.00 Med-Cert can get a background check for you to save you a little time. All you have to do is fill out the attached form and enclose payment of **\$15.00.**

All background check requests must be received at least 1 week prior to clinical.