



## State Certified Nurse Aide Program (STNA) Ohio Department of Health Approved Nurse Aide Training Program

If you have a desire to help others, then attend Penta’s Nurse Aide program and become **State Certified**. This program includes classroom and clinical instruction.



Career possibilities include: hospitals, long term care, hospice, physicians office, assisted living, and more.

Tuition **does not** include the \$100 State Testing Fee. This fee is the responsibility of the student. Check for State Test is due 2 weeks before final test date.

**New low price! Tuition includes a pre-exam study course.**

Start Date	End Date	Day(s)	Times	Tuition
03/05/12	04/30/12	M & W Clinicals on Sat.	6:00 pm–9:30 pm	\$395*

**Space is limited, early registration advised.**

### How to Register for STNA

- Scrubs required for Clinicals.
- Stop by the office to pick up a registration and medical packet **OR**
- Download and print the registration and medical packet from website.
- Financial Aid may be available to qualified applicants by contacting one of the following agency 4-5 weeks **prior** to starting the class.
  - Wood County Jobs and Family Services – 419.352.7566 ext. 8483
  - The Source - 419.213.6315
- **Pre-entrance Exam - \$30**, (non-refundable), paid by student, **1 week prior to exam**. All Nurse Aide (STNA) program candidates, regardless of previous education or degrees, must complete the ACT WorkKeys diagnostic examination. This exam takes approximately 2 ½ hours and consists of three 45 minute components over Math, Reading, and Locating Information.
  - **Call** (419) 661-6555 to schedule an appointment
- Provide a copy of **high school diploma** or **GED**.

- Present proof of a **medical history and physical** (forms provided) within the last 6 months.
- Present **BCI** (fingerprinting) background check with no criminal history, **on or before the FIRST DAY OF CLASS**. (You cannot attend if not completed).

**I swear and affirm that I have not been convicted of a crime, other than minor traffic violations. I understand that Senate Bill 160 will not permit individuals with certain misdemeanors and felonies to work in Long-Term Care Facilities.**

The background check may be done at Penta Career Center, by appointment. Call 419.661.6351 to make an appointment. Or, if this is done by another agency, (see Attachment #1 for locations), the results **must** be mailed to:

**Penta Career Center  
Adult Education Division  
9301 Buck Rd.  
Perrysburg, OH 43551**



# PROGRAM REGISTRATION FORM

Please **PRINT** Clearly

SS #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - 19\_\_\_\_\_

First Name: \_\_\_\_\_ MI/Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Single Parent  
 Displaced Homemaker  Non-Traditional

Race/Ethnicity:  American Indian or Alaska Native  Asian  Black or African American  
 Hispanic / Latin  Native Hawaiian or Other Pacific Islander  White  
 Two or More Races  Race and Ethnicity Unknown  Nonresident Alien

Sex:  Male  Female Handicapped:  Yes  No Are you a Veteran?  Yes  No

Are you a high school graduate?  Yes  No Graduation Date: Month \_\_\_\_\_ Year \_\_\_\_\_

If you are not a high school graduate, have you passed the high school G.E.D. Test?  
 Yes  No Date you Passed: Month \_\_\_\_\_ Year \_\_\_\_\_

Are you a **1st time** Adult student?  Yes  No **If no**, how many years: College \_\_\_\_ Trade \_\_\_\_ Other \_\_\_\_

Place of Employment: \_\_\_\_\_ Position: \_\_\_\_\_

Authorization to: Release Information  Yes  No Release Photo  Yes  No

Are you currently working in the Medical field?  Yes  No

**I, hereby certify that the above information is correct:**

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

\_\_\_\_\_  
Date

Please check the appropriate income range:

- under \$10,000       \$10,000 - \$15,500       \$15,600 - \$20,500
- \$20,600 - \$31,000       \$31,100 - \$40,000       over \$40,000

How/where did you find out about Penta Adult Education Classes? \_\_\_\_\_

**Penta Program/Class Name:** \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Days of Week:  M  T  W  TH

Tuition Cost: \$ \_\_\_\_\_ Paid By:  Cash  MO  MC  Visa  Check # \_\_\_\_\_

Funding Source: \_\_\_\_\_ (Individual, Company, Grant, Loan, Etc.)



## **BCI (fingerprinting) Background Check Agencies**

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### **LUCAS COUNTY**

#### **Area Agency on Aging**

2155 Arlington Avenue  
Toledo, OH 43609  
419.382.0624  
Monday - Friday 9:00 – 3:30  
By Appointment Only

#### **Bureau of Motor Vehicles**

4400 Heatherdowns Blvd.  
Toledo, OH 43614  
Monday - Friday 8:00 – 4:00  
Walk-in Only

#### **National Background Check, Inc.**

Hondros College Building  
6135 Trust Drive, Suite 110  
Holland, OH 43528  
877.932.2435  
Monday - Friday 9:00 – 4:30  
Saturday 9:00 – noon

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### **OTTAWA COUNTY**

#### **Ottawa County Sheriff's Office**

315 Madison Street  
Port Clinton, OH 43452  
419.734.-6826  
Monday - Friday 8:00 – 4:00

### **SANDUSKY COUNTY**

#### **Sandusky County Sheriff's Office**

2323 Countryside Drive  
Fremont, OH 43420  
419.332.2613  
Wednesday 9:00 – 3:00

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### **WOOD COUNTY**

#### **A to Z Health Care, Inc.**

955 Commerce Drive  
Perrysburg, OH 43551  
419.874.5227  
Monday - Friday 8:30 – 5:00

#### **Great Lakes Biomedical**

1021 Sandusky Street, Suite B  
Perrysburg, OH 43551  
419.872.5343  
Monday - Friday 8:00 – 5:00

#### **Wood County Sheriff's Office**

1960 East Gypsy Lane Road  
Bowling Green, OH 43402  
419.354.9137  
  
Tuesday & Wednesday 9:00 – 11:30 a.m.  
Tuesday, Wednesday 1:00 – 4:00 p.m.  
& Thursday 1:00 – 4:00 p.m.



# Personal Medical History Form

(2 pages)

**Directions:** Complete this form prior to your physical examination and give it to the physician for review.

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Sex:**  M  F

**Employer:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Family History:**    **Tuberculosis**     Yes     No        **Diabetes**         Yes     No  
                                  **Mental Illness**     Yes     No        **Heart Disease**     Yes     No

### HAVE YOU EXPERIENCED PROBLEMS WITH ANY OF THE FOLLOWING?

(Check either "YES" or "NO" after each condition)

	YES	NO		YES	NO		YES	NO		YES	NO
Neurological			Lymph nodes			Chest pains			Malaria		
Eyes			Genitals			Chest Palpitations			Rheumatic fever		
Ears			Dizziness			Shortness of breath			Paralysis		
Nose			Frequent headaches			High blood pressure			Cancer or tumors		
Throat			Deafness			Swollen ankles			Jaundice		
Heart			Runny nose			Poor appetite			Diabetes		
Lungs			Frequent sore throats			Chronic indigestion			Arthritis		
Stomach			Frequent colds			Recurrent nausea			Rheumatism		
Intestinal			Chronic cough			Recurrent vomiting			Depression		
Liver			Difficulty Breathing			Stomach ulcers			Nervous breakdown		
Spleen			Coughing up blood			Hernia			Seizures		
Gallbladder			Sinus			Chronic constipation			Major injuries		
Kidneys			Pneumonia			Black or bloody bowel movements			If so, what?		
Bladder			Asthma			Frequency or Painful urination			Allergies		
Bones			Hay fever			Bloody urine			List allergies:		
Joints			Pleurisy			Kidney stones			Operations		
Back			Tuberculosis			Nephritis			List operations:		
Skin			Bronchitis			Mental illness					

## Personal Medical History Form (continued)

**Applicant's Name:** \_\_\_\_\_

List any other serious illnesses that may affect your ability to perform as a health occupations student.

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State details of any prior injuries or operations that might affect your ability to successfully complete classroom, laboratory, and/or clinical components of the program:

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What accommodations do you need in order to perform the functions of a health occupations student?

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Do you have any sensitivity to rubber, latex or powder?     Yes     No

Do you have medical insurance coverage?                       Yes     No

**My signature below indicates that I have answered the above questions fully, completely and to the best of my knowledge.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Physical Examination Form (2 pages)

To be completed by a certified physician or nurse practitioner

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## RECORD OF PHYSICAL EXAMINATION AND REQUIRED IMMUNIZATIONS

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ RR: \_\_\_\_\_

Skin: \_\_\_\_\_ Head: \_\_\_\_\_

Eyes/Pupils: \_\_\_\_\_ Visual Acuity: \_\_\_\_\_

Ears: \_\_\_\_\_ Hearing: \_\_\_\_\_

Nose: \_\_\_\_\_ Mouth/Dental: \_\_\_\_\_

Neck: \_\_\_\_\_ Chest: \_\_\_\_\_

Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_

Breasts: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Genito-Urinary: \_\_\_\_\_ Back: \_\_\_\_\_

Extremities: \_\_\_\_\_ Rectal (optional): \_\_\_\_\_

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

<i>Test #</i>	<i>Date Given</i>	<i>Forearm site</i>	<i>Given By</i>	<i>Date Read</i>	<i>Results</i>	<i>Read By</i>
#1		<i>R or L</i>			_____m	
#2		<i>R or L</i>			_____m	

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:

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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(Measles/Mumps/Rubella) MMR:** Booster required if MMR was administered before 1980.

Date of MMR: \_\_\_\_\_ Date of Booster: \_\_\_\_\_

**Rubella and Rubeola** titers are necessary if born after 1957 and immunization is not done:

Date of Rubella titer: \_\_\_\_\_ Results: \_\_\_\_\_

Date of Rubeola titer: \_\_\_\_\_ Results: \_\_\_\_\_

**Tetanus and Diphtheria:** Booster required within the past 10 years.

Date of Booster: \_\_\_\_\_

**Hepatitis B: (or student may sign separate waiver attached)**

**Series of 3 injections:** Dates: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

**Chicken Pox (Varicella):** Patient must demonstrate immunity through a history of illness, titer, or immunization.

History of chicken pox:  Yes  No

Date of immunization: \_\_\_\_\_ Date of titer: \_\_\_\_\_

Results: \_\_\_\_\_

### **Physician's Certificate**

*This certifies that I have, this day, examined the patient named on this form as to his/her physical fitness for attending a health occupations education program. To the best of my knowledge, this individual is physically and mentally capable of pursuing a health occupations career as indicated below.*

Approved without limitations: \_\_\_\_\_

Approved with the following limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Not approved for the following reasons: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_