



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 81.5 hour program includes 57.5 hours of classroom instruction and 24 hours of clinical instruction.



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

Tuition **does not** include the \$96 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
08/16/10	10/13/10	M & W Clinicals on Sat.	6:00 pm–9:30 pm	\$395*
10/18/10	12/15/10	M & W Clinicals on Sat.	6:00 pm–9:30 pm	\$395*
03/02/11	05/02/11	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.
- 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 **negative TB test** within the last 6 months, **on or before the FIRST DAY OF CLASS**. (You can not attend if not completed). See Attachment #2 for locations.
- 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: (optional)

- | | | |
|--|--|--|
| <input type="checkbox"/> under \$10,000 | <input type="checkbox"/> \$10,000 - \$15,500 | <input type="checkbox"/> \$15,600 - \$20,500 |
| <input type="checkbox"/> \$20,600 - \$31,000 | <input type="checkbox"/> \$31,100 - \$40,000 | <input type="checkbox"/> 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

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

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

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.



County Health Departments T B Testing

Lucas County - \$10.00

Call for appointment
419.213.4113

635 N. Erie St.
Toledo, OH 43604

Non-residents Welcome

M, T, W, F 8:30 – 11:30 a.m.
1:00 – 3:30 p.m.

Monroe County

734.240.7800

2353 S. Custar Rd.
Monroe, MI

Ottawa County - Free

No appointment needed
419.734.6800

1856 E. Perry Street
Port Clinton, OH 43452

Non-residents welcome

2nd & 4th Wednesday each month

Wood County - \$10.00

Call for appointment
419.352.8402

Non-residents welcome

1840 E. Gypsy Lane Rd.
Bowling Green, OH 43402

6000 Wales Rd. - One day/month
Northwood, OH 43619



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.

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:

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

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>
<i>#1</i>		<i>R or L</i>			_____m	
<i>#2</i>		<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:

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: 1st _____ 2nd _____ 3rd _____

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: _____

Hepatitis B Immunization Form (continued)

Section II: Hepatitis B Vaccine Refusal

I refuse to receive the Hepatitis B vaccination at this time. I understand that by refusing to receive this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. I hereby release and agree to hold Penta Career Center employees or agents and Penta Adult & Continuing Education employees or agents harmless from any claims, demands, or causes of action arising out of my choice to refuse the administration of the vaccine.

If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with the Hepatitis B vaccine, I can then make arrangements to receive the vaccination series. I will then notify the Health Occupations Office regarding my decision to receive the series, as well as to provide the Office with documentation of the dates of the vaccine series as identified in Section III of this form.

Name of Health Occupations Applicant: _____
(Please Print) Last First Middle

Signature of Applicant: _____ **Date:** _____

Section III: Hepatitis B Vaccine Administration

I have received or am in the process of receiving the Hepatitis B vaccine, as indicated below. I hereby release and agree to hold Penta Career Center employees and Penta Adult & Continuing Education employees or agents harmless from any claims, demands, or causes of action arising out of my choice to receive the administration of the vaccine.

Name of Health Occupations Applicant: _____
(Please Print) Last First Middle

Signature of Applicant: _____ **Date:** _____

Required Information:

The following information is to be completed by an official representative of the physicians' office or clinic or an agency where vaccine administration is being or has been received by the health occupations student.

Date of Vaccine: 1st Dose _____ 2nd Dose _____ 3rd Dose _____

Physician/Nurse Practitioner Name: _____
(Please Print)

Agency: _____ Phone Number: _____

Address: _____

Official representative where vaccine series is being or had been received by the health occupations student:

Name: _____ Title: _____

Date: _____

Signature of representative indicating the above information is true and correct