Classes are five weeks long and scheduled on a regular basis, with a combination of class, lab and clinical days. **Classes are not eligible for financial aid. Tuition is due one week prior to first class day.** Space is limited. Applicants should sign up early. Minimum age is 16-years-old. No GED or High School diploma required. Students must be present every day and pass each exam. Students that fail to meet attendance and grade requirements will be withdrawn from class, **no exceptions.**

### Course Requirements:

**Identification**—Applicants must present a valid photo ID before the first class day. Examples of valid forms of photo ID are:

<table>
<thead>
<tr>
<th>U.S. State issued identification</th>
<th>Student identification</th>
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</thead>
<tbody>
<tr>
<td>U.S. financial institution issued identification</td>
<td>U.S. government-issued Military I.D.</td>
</tr>
<tr>
<td>Work identification</td>
<td>U.S. Passport</td>
</tr>
<tr>
<td>Alien Registration Card</td>
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</table>

**Background Check and Drug Test:**

Obtain your criminal background history check and drug test on your own by going to DATCS. You will need to take the DATCS form in this packet with you to get your drug test and background check. The locations are on the bottom of the form. The fee is $30 for the background check and $16 for the drug test and is the student’s responsibility to pay for it. **The Background Check and Drug Test need to be done within 30 days of the first class day. If test results are older than that they will need to be retaken.** The results will be sent directly to the college.

**Tuition, Supplies, Immunization, Physical Requirements & Class Dates** *(Prices listed are estimates).*

- **Tuition and Fees:** $720.00 *(due a week before class begins).* 100% Refund if withdrawn prior to 1st class day (minus $15 matriculation fee), 70% refund if withdrawn by the end of the 2nd day of class (minus $15 matriculation fee). Fees include: Student insurance and state testing fee.

- **Basic Life Support for Healthcare Providers:** Certification through the American Heart Association is required before first class day. You can sign up for the BLS Certification Class given at Kilgore College by calling 903-983-8645. It is given once a month at the Longview campus.

- **Textbook is $32.** Fuzy, J. (2019). Hartman’s, **Nursing Assistant Care:** The Basics (5th Ed.). Albuquerque, NM. Hartman Publishing, Inc. *Bring the required textbook to class the first day. Study abbreviations (page 250 in textbook) for a test on the second day of class.*

Supplies consist of the following and can be purchased at Scrubs Galore N More, 815 N. 4th St., Longview.

- **Gait belt/transfer belt**
- **Stethoscope**
- **Sphygmomanometer** (blood pressure cuff, analog ONLY, no digital)
- **Uniform**: White uniform with royal blue student apron, available at Scrubs Galore N More at 815 N. 4th St., Longview. *Uniform is required the first class day.* On the first class day, instructor will explain the uniform and professional appearance (ex., facial piercings, unnaturally colored hair, and artificial nails. Your name tag will be your student ID.
- **Watch** with second hand.
- **White shoes**: Closed toe with nonslip soles.
- **Immunizations**: (Required) *Due before the first class day.* You will need to turn in the Immunization form with the dates of your immunizations written on it, and have your physician, or nurse sign the form.
- **Physical Requirements**: Students must be physically & mentally able to perform the necessary tasks and skills required of a nursing assistant including adequate vision and hearing as well as transferring, moving, ambulating, or lifting patients on a regular basis.

### 2022 Classes

<table>
<thead>
<tr>
<th>Day Classes 7:45 am to 12:30 pm Monday-Thursday</th>
<th>Evening Classes 4:00 pm to 8:45 pm Monday-Thursday</th>
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<tbody>
<tr>
<td>January 18 to February 28</td>
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<td>March 3 to April 20</td>
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<td>April 21 to June 2</td>
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<td>June 23 to August 4</td>
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<td>August 22 to October 3</td>
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<td>October 6 to November 16</td>
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</table>

### Certification
Program completers are eligible to register online for state certification.
- A valid photo ID.
- Test Sites and test schedules may be found at: [https://www.prometric.com/nurseaide/tx](https://www.prometric.com/nurseaide/tx)

*Program completers have two years from their program completion date to take the state exam to become certified.*

### Additional Information
Texas Health & Human Services phone number: 512-438-2050 or 800-452-3934

**For information on:**
- **Recertification & Renewal**
- **Nurse aide in-service CBT’s**

Kilgore College seeks to provide equal educational and employment opportunities without regard to race, color religion, national origin, sex, age, disability, marital status, or veteran status.

**Kilgore College Longview, 300 High St., Longview, TX 75601**
903-236-2036

Updated 2/10/2022
Kilgore College WDCE Course Registration Form

Registration will be accepted only if class space is available. Payment is due before the class starts.

Date: __________________________

SS#: __________ - __________ - __________

Student ID#: __________________________

Name: ____________________________ (Last Name) ____________________________ (First Name) ____________________________ (Middle Initial)

Mailing Address: ____________________________ County: ____________________________

City: ____________________________ State: __________ Zip: ____________________________

Home Phone: ________________ Business or Cell Phone: ____________________________

Email: ____________________________

Date of Birth: ____________________________ Gender: Male ______ Female ______

US Citizen: Y _____ N _____ If no, what country: ____________________________

Colleges and universities are asked by many, including the federal government, accrediting associations, college guides, newspapers and our own college/university communities, to describe the racial/ethnic backgrounds of our students and employees. In order to respond to these requests, we ask you to answer the following two questions:

1. Are you Hispanic or Latino?
   (Are you a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race?)
   _____ Yes _____ No _____

2. Please select the racial category or categories that you most closely identify. Check as many as apply: American Indian or Alaska Native _____
   American Indian or Alaska Native _____
   Black or African American _____
   Native Hawaiian or Other Pacific Islander _____
   White _____

<table>
<thead>
<tr>
<th>Course Name</th>
<th>Course Number</th>
<th>Start Date</th>
<th>Tuition</th>
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</table>
KILGORE COLLEGE CNA PROGRAM
PHYSICAL EXAMINATION INFORMATION

Physical examination with immunization information must be completed and on file prior to registration. Your health care provider must initial each immunization on the form to indicate it was reviewed by them. All immunizations must be completed; except for Hepatitis B; which must be started prior to enrollment. Attach a copy of your shot records with the physical exam form.

(Note: This form MUST be used and signed by your health care provider for your physical.)

IMMUNIZATIONS

SB 7, Article 8, Chapter 224 Adoption of Vaccine Preventable Diseases Policies by Health Care Facilities states that health care facilities shall adopt and implement policies to protect its patients from vaccine preventable diseases. All immunizations should be completed before registration to the CNA program. (Your HepB completion may take a few months longer.) These immunizations may be obtained from the following agencies as an example:

1. Your personal physician.
2. CVS Pharmacy, Walgreens, etc.
3. County Health Departments
4. Medical Clinics

Physical examination: A health-care practitioner must complete the physical examination form. Please complete the OSHA Respirator Medical Evaluation Questionnaire and sign the Essential Job Functions form. Take those with you to your physical exam appointment for review by your health-care practitioner.

TB skin test: Tuberculosis test is required annually.

MMR: Measles, Mumps and Rubella (MMR) booster (2 vaccinations after 15 months of age) or evidence of immunity. Regardless of age, must show proof of:

1. Documentation of two (2) doses of MMR after the age of 15 months or
2. Immunity of measles, mumps and rubella by titer (include copy of lab report with titer results)

VARICELLA (Chicken Pox/Shingles) (2 vaccinations, 28 days apart) or evidence of immunity. Regardless of age must show proof of:

1. Documentation of two (2) doses of varicella vaccine at least 4 weeks apart or
2. Immunity of varicella by titer (include copy of lab results with titer results)

TETANUS/DIPTHERIA/PERTUSSIS (Tdap): CNA students are required to provide proof of Tdap vaccination. Required every 10 years.

FLU VACCINE: All health occupation majors are required to submit proof of immunization due by November 1 every year. If admitted between the months September and March, must submit immunization prior to class registration.

HEPATITIS B: Hepatitis B vaccination series and titer.
1. Vaccine series
   a. Obtain three doses of Engerix-B or Recombivax
      i. Second dose should be one month from first dose
      ii. Third dose should be six months from first dose.
   b. Obtain two doses of Heplisav-B
      i. Vaccines should be one month apart.
c. Titer
   i. If the student did not have a titer done within 1 to 2 months after the administration of the final vaccine dose, the student should have a single vaccine (booster) with titer done between 30-60 days after receipt.
   ii. If the student has a negative antibody response (defined as <10mIU/mL) after the booster, the student should be revaccinated with to complete a second series.
   iii. If the student still does not respond after revaccination, they will be considered a non-responder and should seek medical care for evaluation for lack of response and counseling.

COVID-19 (Novel Coronavirus 2019) (complete vaccination series)

a. Documentation of two (2) doses of the Phizer vaccine at least 21 days apart with booster 5 months from second vaccine or
b. Documentation of two (2) doses of the Moderna vaccine at least 28 days apart with booster 5 months from second vaccine or
c. Documentation of one (1) dose of the Johnson & Johnson vaccine with booster 2 months after that dose.

CPR: The American Heart Association, BLS CPR Certification is required for all nursing students. No other CPR certifications are accepted.
Kilgore College Health Science
Immunizations and Physical Exam

This form must be signed by a healthcare professional. Attach proof of vaccines/titers. Must have all records turned in by due date in packet.

STUDENT NAME ______________________________________ Phone: _________________________
Address: _________________________________________________________________________ DOB: _________________________

<table>
<thead>
<tr>
<th>Proof Attached</th>
<th>Date TST Performed/Placed</th>
<th>TST Read</th>
<th>Results in mm</th>
<th>Date QFT-G done</th>
<th>Results of QFT-G</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TB Test (please circle test done)</td>
<td></td>
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<tr>
<td>TST must be read between 48-72 hours.</td>
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<tr>
<td>Those with previous positive results must have copy of results in mm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest x-ray is for those with documented previous positive TB test OR QuantiFERON®-TB Gold test (QFT-G)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence of Measles, Mumps, and Rubella or, MMR Vaccination (2) given after 15 months of age</th>
<th>(1) Date:</th>
<th>Verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If titer done, must provide copy</td>
<td>(2) Date</td>
<td>Verified by:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence of Varicella / Chicken Pox</th>
<th>(1) Date:</th>
<th>Verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella Vaccination (2) given at least 4-8 weeks apart</td>
<td>(2) Date</td>
<td>Verified by:</td>
</tr>
<tr>
<td>If titer done, must provide copy</td>
<td>Date of Titer:</td>
<td>Verified by:</td>
</tr>
<tr>
<td>Results of Titer:</td>
<td>Verified by:</td>
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</table>

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<tr>
<th>TDAP (within past 10 years)</th>
<th>Date:</th>
<th>Verified by:</th>
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</table>

<table>
<thead>
<tr>
<th>Flu Vaccine (current year)</th>
<th>Date:</th>
<th>Verified by:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hepatitis B Immunization Series of 2 or 3 vaccines (depending on type) and titer</th>
<th>(1) Date:</th>
<th>Verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Engerix-B or Recombivax: Dose #1 before first class day, Dose #2 one month after first shot, Dose #3 at least 6 months after first shot</td>
<td>(2) Date</td>
<td>Verified by:</td>
</tr>
<tr>
<td>For Heplisav-B: Dose #1 before first class day, Dose #2 one month after first shot Titer 30-60 days after final shot If titer &lt; 10 mL/IU, student must have second series</td>
<td>(3) Date</td>
<td>Verified by:</td>
</tr>
<tr>
<td>Date of Titer:</td>
<td>Verified by:</td>
<td></td>
</tr>
<tr>
<td>Results of Titer:</td>
<td>Verified by:</td>
<td></td>
</tr>
</tbody>
</table>

Updated 2/10/2022
### Meningitis Vaccine
Meningococcal polysaccharide vaccine (Menomune or MPSV4) or meningococcal conjugate vaccine (Menactra or Menveo or MCV4)

<table>
<thead>
<tr>
<th>Date:</th>
<th>Verified by:</th>
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</table>

### COVID-19 Immunization
- **Pfizer**: Series of 2 vaccines, 21 days apart and booster 5 months from second vaccine.
- **Moderna**: Series of 2 vaccines, 28 days apart and booster 5 months after second vaccine.
- **Johnson & Johnson**: One vaccine with booster 2 months after first dose.

<table>
<thead>
<tr>
<th>(1) Date:</th>
<th>Verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) Date</td>
<td>Verified by:</td>
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<tr>
<td>(3) Date</td>
<td>Verified by:</td>
</tr>
<tr>
<td>(4) Date</td>
<td>Verified by:</td>
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</table>

**Brand:**

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**Physical- To Health Care Provider:**

This report, signed by the physician, physician’s assistant, or nurse practitioner, shall be provided to the health science program. This report shall indicate that the student does not have any health condition(s) that would create a hazard to themselves, employees, or patients.

I have verified that the individual I have examined is the named individual on this form and find that this individual (please check all that apply):

- _____ is free of any medical condition and/or contagious disease and does not pose a health risk to others
- _____ is free of any mental or physical impairment that would prevent the student from meeting his/her clinical practicum training obligation
- _____ I have reviewed the essential job functions of the student’s program.
- _____ The student has the following (impairment) which could interfere with the performance of his/her essential job functions:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Health Care Provider Signature

Date

Health Care Provider Name Printed/Typed/Stamped

Address/City/State/Zip Code

Telephone

---

*Acceptable evidence of vaccines
Vaccine administered after 9/1/99 shall include month, day and year each vaccine administered. Documentation of vaccine that includes signature or stamp of physician/designee or public health personnel. An official immunization record generated from a state or local health authority such as a registry or a record received from school officials is also acceptable.
Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:________________________________________________________________________
2. Your name:__________________________________________________________________________
3. Your age (to nearest year):________________________________________________________________
4. Sex (circle one): Male/Female
5. Your height: ________ ft. ________ in.
6. Your weight: ____________ lbs.
7. Your job title:_________________________________________________________________________
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): __________________________
9. The best time to phone you at this number: ______________________
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
   a. ______ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ______ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No
   If “yes,” what type(s): __________________________________________

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes/No
2. Have you ever had any of the following conditions?
   a. Seizures: Yes/No
   b. Diabetes (sugar disease): Yes/No
   c. Allergic reactions that interfere with your breathing: Yes/No
   d. Claustrophobia (fear of closed-in places): Yes/No
e. Trouble smelling odors: Yes/No

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis: Yes/No
   b. Asthma: Yes/No
   c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you’ve been told about: Yes/No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
   d. Have to stop for breath when walking at your own pace on level ground: Yes/No
   e. Shortness of breath when washing or dressing yourself: Yes/No
   f. Shortness of breath that interferes with your job: Yes/No
   g. Coughing that produces phlegm (thick sputum): Yes/No
   h. Coughing that wakes you early in the morning: Yes/No
   i. Coughing that occurs mostly when you are lying down: Yes/No
   j. Coughing up blood in the last month: Yes/No
   k. Wheezing: Yes/No
   l. Wheezing that interferes with your job: Yes/No
   m. Chest pain when you breathe deeply: Yes/No
   n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack: Yes/No
   b. Stroke: Yes/No
   c. Angina: Yes/No
d. Heart failure: Yes/No  
e. Swelling in your legs or feet (not caused by walking): Yes/No  
f. Heart arrhythmia (heart beating irregularly): Yes/No  
g. High blood pressure: Yes/No  
h. Any other heart problem that you've been told about: Yes/No

6. Have you ever had any of the following cardiovascular or heart symptoms?  
a. Frequent pain or tightness in your chest: Yes/No  
b. Pain or tightness in your chest during physical activity: Yes/No  
c. Pain or tightness in your chest that interferes with your job: Yes/No  
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No  
e. Heartburn or indigestion that is not related to eating: Yes/No  
f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you currently take medication for any of the following problems?  
a. Breathing or lung problems: Yes/No  
b. Heart trouble: Yes/No  
c. Blood pressure: Yes/No  
d. Seizures: Yes/No

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)  
a. Eye irritation: Yes/No  
b. Skin allergies or rashes: Yes/No  
c. Anxiety: Yes/No  
d. General weakness or fatigue: Yes/No  
e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently): Yes/No
11. Do you currently have any of the following vision problems?  
a. Wear contact lenses: Yes/No  
b. Wear glasses: Yes/No  
c. Color blind: Yes/No  
d. Any other eye or vision problem: Yes/No
12. Have you ever had an injury to your ears, including a broken ear drum: Yes/No

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing: Yes/No
   b. Wear a hearing aid: Yes/No
   c. Any other hearing or ear problem: Yes/No

14. Have you ever had a back injury: Yes/No

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet: Yes/No
   b. Back pain: Yes/No
   c. Difficulty fully moving your arms and legs: Yes/No
   d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
   e. Difficulty fully moving your head up or down: Yes/No
   f. Difficulty fully moving your head side to side: Yes/No
   g. Difficulty bending at your knees: Yes/No
   h. Difficulty squatting to the ground: Yes/No
   i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
   j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

**Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.**

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No
   If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No
   If "yes," name the chemicals if you know them: ________________________________
   ________________________________

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
   a. Asbestos: Yes/No
   b. Silica (e.g., in sandblasting): Yes/No
   c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
   d. Beryllium: Yes/No
   e. Aluminum: Yes/No
   f. Coal (for example, mining): Yes/No
g. Iron: Yes/No
h. Tin: Yes/No
i. Dusty environments: Yes/No
j. Any other hazardous exposures: Yes/No
   If "yes," describe these exposures:
   ____________________________________________________________
   ____________________________________________________________

4. List any second jobs or side businesses you have: ____________________________
   ______________________________________________________________

5. List your previous occupations: ___________________________________________
   ______________________________________________________________

6. List your current and previous hobbies: ____________________________________
   ______________________________________________________________

7. Have you been in the military services? Yes/No
   If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No
   If "yes," name the medications if you know them: ______________________

10. Will you be using any of the following items with your respirator(s)?
    a. HEPA Filters: Yes/No
    b. Canisters (for example, gas masks): Yes/No
    c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?
    a. Escape only (no rescue): Yes/No
    b. Emergency rescue only: Yes/No
    c. Less than 5 hours per week: Yes/No
    d. Less than 2 hours per day: Yes/No
    e. 2 to 4 hours per day: Yes/No
    f. Over 4 hours per day: Yes/No
12. During the period you are using the respirator(s), is your work effort:
   
a. Light (less than 200 kcal per hour): Yes/No
   If "yes," how long does this period last during the average shift: __________ hrs. __________ mins.
   Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.
   
b. Moderate (200 to 350 kcal per hour): Yes/No
   If "yes," how long does this period last during the average shift: __________ hrs. __________ mins.
   Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
   
c. Heavy (above 350 kcal per hour): Yes/No
   If "yes," how long does this period last during the average shift: __________ hrs. __________ mins.
   Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No
   If "yes," describe this protective clothing and/or equipment: __________

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):
   Name of the first toxic substance: ___________________________
   Estimated maximum exposure level per shift: _________________________
   Duration of exposure per shift: ________________________________
Name of the second toxic substance: ________________________________
Estimated maximum exposure level per shift: ______________________
Duration of exposure per shift: _________________________________
Name of the third toxic substance: ________________________________
Estimated maximum exposure level per shift: ______________________
Duration of exposure per shift: _________________________________
The name of any other toxic substances that you'll be exposed to while using your respirator: ________________________________
                                           ________________________________
                                           ________________________________
19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):
                                           ________________________________

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]
The following are essential job functions for any Nursing Assistant, Vocational Nurse, or Registered Nurse as compiled from observations of a wide variety of job experience.

1. VISUAL ACUITY:
   - Maintain a minimum standard of visual acuity required to observe a client’s physical condition from a distance of 0-100 feet
   - Maintain a minimum standard of visual acuity for operation of equipment
   - Maintain a minimum standard of visual acuity for visual inspection of the environment, use of computer terminals, extensive reading, and using measurement devices at distances close to the eyes
   - Perceive color changes (e.g.: dermatological conditions, skin tone)
   - Recognize non-verbal behaviors

2. HEARING ACUITY:
   - Perceive the nature of sound and receive and interpret detailed information through oral communication
   - Hear and respond to soft voices, heart/breath sounds, hear Kortokoff sounds (blood pressure), alarms, patient assistance call devices/timers, and accurately hear telephone conversations
   - Hear and retain pertinent information to relay instructions

3. COMMUNICATION ABILITY:
   - Express, exchange or interpret ideas by means of the spoken or written word accurately, loudly and quickly as necessary
   - Communicate sufficiently nonverbally, in speech, reading and writing to appropriately interact with individuals and to communication their needs promptly and effectively for the client’s best interest

4. DIGITAL DEXTERITY:
   - Move the wrists, hands, or fingers in a repetitive motion either singularly or simultaneously
   - Coordinate movements into smooth, fluid motions including but not limited to eye/hand coordination activities and eye/hand/foot coordinated activities
   - Extend hand(s) and arm(s) in any direction (forward, downward, above shoulder level, etc.)
   - Apply pressure to an object with the fingers and palm; both a firm/strong grasp and light grasp
   - Ability to palpate both superficially and deeply to discriminate tactile sensations

5. PHYSICAL ABILITY:
   - Stand for sustained periods of time
   - Move from one area to another quickly, particularly for long distances and to be on the feet/mobile for 4-8 hours consecutively and maneuver in small spaces
   - Maintain body equilibrium to prevent falling when walking, standing, or crouching on narrow, slippery, or erratically moving surfaces exceeding what is required for ordinary locomotion and maintenance of body equilibrium
   - Ascend or descend stairs, stools, ramps, and the like using the feet and legs or hands and arms; move self from one position to another, e.g. supine to/from standing, supine to/from sitting
   - Pull/push, drag, haul, or tug objects weighing between 10 and 50 pounds in a sustained motion; lift objects of varying sizes and weights between 10 and 50 pounds or carry objects of varying sizes and weights between 10 and 50 pounds from a lower to a higher position or horizontally
   - Bend body at the waist, spine, hips or knees downward and forward in a stooping motion, move about on hands and/or knees, and return to an upright position requiring full use of the lower extremities and back muscles

6. ADAPTIVE ABILITY:
   - Complete tasks or job functions within deadlines, many times under stress produced by both academic study and nursing care
   - Complete required tasks/functions under stressful conditions.
• Track and complete multiple tasks at the same time.
• Perform independently with minimal supervision.
• Interact appropriately with diverse personalities.
• Ability to travel to agencies and hospitals, and to homes with unpredictable environments
• Ability to adapt to a physically and emotionally demanding program

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS, AND MEET THESE STANDARDS FOR THE NURSING PROGRAMS AT KILGORE COLLEGE. IF I CANNOT MEET THESE STANDARDS, I MAY BE DISMISSED FROM THE PROGRAM.

Signature______________________________________ Date______________________
I. Barred forever
   1. Chapter 19, Penal Code: Criminal homicide
      i. Murder
      ii. Capital murder
      iii. Manslaughter
      iv. Criminally negligent homicide
   2. Chapter 20, Penal Code: Kidnapping, unlawful restraint, and smuggling of persons
      i. Unlawful restraint
      ii. Kidnapping
      iii. Aggravated kidnapping
      iv. Smuggling of persons
      v. Continuous smuggling of persons
      vi. Operation of stash house
   3. Section 21.02, Penal Code: Continuous sexual abuse of young child or children
   4. Section 21.11, Penal Code: Indecency with a child
   5. Section 22.011, Penal Code: Sexual assault
   6. Section 22.02, Penal Code: Aggravated assault
   7. Section 22.04, Penal Code: Injury to a child, elderly individual, or disabled individual
   8. Section 22.041, Penal Code: Abandoning or endangering child
   9. Section 22.08, Penal Code: Aiding suicide
   10. Section 25.031, Penal Code: Agreement to abduct from custody
   11. Section 25.08, Penal Code: Sale or purchase of child
   12. Section 28.02, Penal Code: Arson
   13. Section 29.02, Penal Code: Robbery
   14. Section 29.03, Penal Code: Aggravated robbery
   15. Section 21.08, Penal Code: Indecent exposure
   16. Section 21.12, Penal Code: Improper relationship between educator and student
   17. Section 21.15, Penal Code: Invasive visual recording
   18. Section 22.05, Penal Code: Deadly conduct
   19. Section 22.021, Penal Code: Aggravated sexual assault
   20. Section 22.07, Penal Code: Terroristic threat
   21. Section 32.53, Penal Code: Exploitation of child, elderly individual, or disabled individual
   22. Section 33.021, Penal Code: Online solicitation of a minor
   23. Section 34.02, Penal Code: Money laundering
   24. Section 35A.02, Penal Code: Health care fraud
   25. Section 36.06, Penal Code: Obstruction or retaliation
   26. Section 42.09, Penal Code: Cruelty to livestock animals
   27. Section 42.092, Penal Code: Cruelty to non-livestock animals
1. A conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed by this subsection

II. Barred for FIVE years (fifth anniversary of date of conviction)
   1. Section 22.01, Penal Code: Assault, that is punishable as a Class A misdemeanor or as a felony
   2. Section 30.02, Penal Code: Burglary
   3. Chapter 31, Penal Code: Theft, that is punishable as a felony
   4. Section 32.45, Penal Code: Misapplication of fiduciary property or property of financial institution, that is punishable as a Class A misdemeanor or a felony
   5. Section 32.46, Penal Code: Securing execution of document by deception, that is punishable as a Class A misdemeanor or a felony
   6. Section 37.12, Penal Code: False identification as peace officer; misrepresentation of property
   7. Section 42.01(a)(7), (8), or (9), Penal Code: Disorderly conduct

III. A person who is placed on deferred adjudication community supervision for an offense listed in this section, successfully completes the period of deferred adjudication community supervision, and receives a dismissal and discharge in accordance with Article 42A.111, Code of Criminal Procedure, is not considered convicted of the offense for which the person received deferred adjudication community supervision
AUTHORIZATION FORM: NON - REGULATED DRUG / ALCOHOL TESTING

Company Name: KILGORE COLLEGE CNA PROGRAM
Company DER: JACKIE MCDONALD

Account Number: 3749A / 494215
Phone: 903-983-8645
Fax: 

Donor Name: __________________________
Donor SSN: __________________________

Scheduled Date: __________________________

Reason: 
☐ Pre-employment
☐ Random
☐ Post-Accident
☐ Reasonable Suspicion
☐ Return-to-Duty
☐ Follow-Up
☐ **Pre-Access

Signature of DER or Designated Supervisor

***STUDENTS ARE RESPONSIBLE FOR ALL FEES ASSOCIATED WITH DRUG TESTING AND BACKGROUND CHECKS***

☐ DRUG TEST $18.00
☐ ALCOHOL TEST
☐ BACKGROUND $30.00
☐ OTHER TEST: ________________

EMAIL, FAX OR GIVE EMPLOYEE AUTHORIZATION FORM

Longview  frontdesk@datcs.com  Fax  903-234-1948  Submit
Bossier City  frontbossier@datcs.com  Fax  318-212-1128  Submit
Tyler  fronttyler@datcs.com  Fax  903-534-5983  Submit
Wichita Falls  wffront@datcs.com  Fax  940-264-8808  Submit

From the time a donor is notified by a company representative to submit to a drug and/or alcohol test, he or she will be allowed thirty minutes plus travel time to arrive and check in with the approved collection site. By signing this document, I acknowledge that I have read and understand the preceding statement. I furthermore acknowledge that my failure to submit to these instructions will subject me to the disciplinary action outlined in the company's drug/alcohol policy. Once the testing process begins, I will not be allowed to leave the premises. I acknowledge that leaving the facility will be reported as a REFUSAL to test.

DONOR SIGNATURE:

4000 U.S. HWY 259
North Longview, Texas 75605
(903) 234-1136

3180 Park Center Drive
Tyler, Texas 75703
(903) 514-3893

1701 Old Minden Rd., Suite 14C
Bossier City, Louisiana 71111
(318) 212-1125

4701 Southwest Pkwy, Ste. 18
Wichita Falls, Texas 76310
(940) 264-8805

Updated 2/10/2022
STUDENT CHECK LIST FOR CERTIFIED NURSE AIDE

NAME: ___________________________ ID #: ___________________________

_____ Completed Registration Form

_____ Copy of Valid Photo ID (circle type)

<table>
<thead>
<tr>
<th>U.S. State issued identification</th>
<th>U.S. financial institution issued identification</th>
<th>U.S. government-issued Military I.D.</th>
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<td>Student identification</td>
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<tr>
<td>Work identification</td>
<td>U.S. Passport</td>
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<tr>
<td>Alien Registration Card</td>
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</tr>
</tbody>
</table>

_____ Documentation of MMR:

Vaccine doses 1. ______ 2. ______ or titers Measles ______ Mumps _____ Rubella ______

_____ Documentation of Varicella (Chickenpox):

Vaccine doses 1. ______ 2. ______ or titer ______

_____ Documentation of Tdap immunization ______

_____ Documentation of Influenza vaccine ______

_____ Documentation of Hepatitis B immunization (must have at least first dose)

Vaccine doses 1. ______ 2. ______ 3. ______ Titer ______

_____ Documentation of COVID-19 immunization

Vaccine doses 1. ______ 2. ______ 3. ______

_____ Current and negative Tuberculosis test

_____ Physical Examination form completed and cleared

_____ Essential Job Functions form signed

_____ Cleared to wear respirator

_____ Current and clear background check

_____ Current and clear drug screen

_____ Nurse Aide Registry/ Employee Misconduct Registry check

_____ Basic Life Support for Healthcare Providers certification, American Heart Association

_____ Payment of tuition

____________________________________
Signature of KC staff member completing checklist
BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS

This course is free. The registration deadline is one week prior to the course date.

To register for this course, please complete the WDCE Registration form included in this packet and email to: jfranklin@kilgore.edu

For more information call 903-988-7452.

Workforce Development
Community Education

KILGORE COLLEGE