AMERICAN INSTITUTE OF HEALTH

800 CROSS POINTE ROAD, SUITE K, GAHANNA, OH 43230
TEL: (614) 536-1336, FAX: (614) 694-0866
E-MAIL: ADMISSIONS.AIOH@GMAIL.COM
WWW.AI-OH.COM

CERTIFIED NURSING ASSISTANT (CNA) AND/OR HOME HEALTH AIDE (HHA)

APPLICATION FORM

YOUR APPLICATION WILL NOT BE PROCESS IF ALL APPLICATION QUESTIONS ARE NOT FULLY ANSWERED

PLEASE SELECT YOUR ADMISSION REQUEST

☐ Check here if you are enrolling in a CNA Training Program
☐ Check here if you are enrolling in a HHA Training Program
☐ Check here if you are enrolling in Adult & Pediatric First Aid/CPR & AED Training Program
☐ Check here if you are enrolling in Basic Life Support Training Program

SECTION I(REQUIRED)

Last Name	MI	First Name	Sex ☐ Male ☐ Female
Mailing Address (Number & Street or P.O. Box Number		City	State / Zone
Date of Birth ____/____/_____	*Social Security Number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If you use an invalid SSN, your application process may be delayed	Driver's License or State ID No. ______________ State ______	Telephone No.
Height	Weight	Hair Color	Eye Color
Email address:		Cell Phone No.	
Race (Optional)	☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American ☐ Native American ☐ Others		

SECTION II(REQUIRED)

1. Have you been CONVICTED, at any time, of any crime, other than a minor traffic violation?
   - If yes, list conviction: ________________________Court of conviction: ____________________Date: __________
2. Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
   - If yes, indicate the type and number of license/certificate: ____

DO YOU HAVE A HIGH SCHOOL DIPLOMA? ☐ Yes ☐ No
- If yes, please attached a copy of your High School Diploma?

DO YOU HAVE FIRST AID, CPR/AED CERTIFICATE? ☐ Yes ☐ No
- If yes, please attached a copy of your First Aid, CPR/AED Certificate?

SECTION III (REQUIRED) EDUCATIONAL BACKGROUND: Please attached copies

Name of School/College Attended	Address	Date Attended	Date Graduated
		____/____/_____	____/____/_____

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PROGRAM ACKNOWLEDGEMENT

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I have read the American Institute of Health; Certified Nursing Assistant (*CNA*) Program Policies and Procedures

I understand that I am responsible for reading and abiding by the policies and procedures of the program that can be http://www.ai-oh.com

______________________________ ______________________________

Signature of Student Date

____

Student Name (*print*)

Release of Information

I agree to release my name, address, and AMERICAN INSTITUTE OF HEALTH, Identification number, dates of attendance and program status when requested by government or regulatory bodies.

To withhold disclosure of this directory information, I must provide written notification separately to the AMERICAN INSTITUTE OF HEALTH; CNA Program Coordinator.

All changes of name, address or phone information during my enrollment in the program shall be reported to the AMERICAN INSTITUTE OF HEALTH; Admission and Records Office immediately.

______________________________ ______________________________

Signature of Student Date

____

Student Name (*print*)

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ENROLLMENT AGREEMENT

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Student: ____ Date: ______________

Address: ___________________________________ City: ____________ State: ____ Zip: ______

Phone Number: _________________________ S.S. Number: _________________________

E-mail: ____

I am hereby enrolling in the following academic program and my enrollment is subject to the terms and conditions stated in this enrollment agreement.

Program Name: NURSING Aide Assistant **Start Date:** ______________

Program length: 76 Clock Hours. This program is normally completed in two (2) Weeks.

Tuition and Fees for Current Term	**Payment:**
Registration Fee.....................$20.00	All tuition and fees are payable in the first week of enrollment for classes. A total payment of is due prior to start of classes
Book Fee...............................$25.00	
Laboratory Fee: $50.00	
Tuition Fee: $350.00	
Total projected fees including Book/Handout for students: $445.00	

Uniforms and Clinical Supplies (WOMEN)

Item No.	Description	Qty	Unit Cost US$	Remarks
01014438	Black*Aneriod/Clinical	1	$58	
01243813	Black/Hot Pink*Pulse Oximeter	1	$45	
01553**829-38**	Pewter***Pant**	1	$28	**S – M – L – XL – XS - 2XL**
015545**00-05**	Pewter***Top**	1	$29	**S – M – L – XL – XS - 2XL**
ITEMS TOTAL		**4**	**$160**	

Uniforms and Clinical Supplies (MEN)

Item No.	Description	Qty	Unit Cost US$	Remarks
01014438	Black*Aneriod/Clinical	1	$58	
01243813	Black/Hot Pink*Pulse Oximeter	1	$45	
015539**61-69**	Pewter***Pant**	1	$28	**S – M – L – XL – XS - 2XL**
015545**91-96**	Pewter***Top**	1	$29	**S – M – L – XL – XS - 2XL**
ITEMS TOTAL		**4**	**$160**	

Tuition and fee charges are subject to change at the school's discretion. Any tuition or fee increases will become effective for the school term/sessions following student notification of the increase.

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Cancellation and Settlement policy

This enrollment agreement may be canceled within five calendar days after the date of signing provided that the school is notified of the cancellation in writing.

If such cancellation is made, the school will promptly refund in full all tuition and fees paid pursuant to the enrollment agreement and the refund shall be made no later than thirty days after cancellation. This provision shall not apply if the student has already started academic classes.

Refund Policy

If the student is not accepted into the training program, all monies paid by the student shall be refunded. Refunds for books, supplies and consumable fees shall be made in accordance with Ohio Administrative Code section 3332-1-10.1. Refundable fees shall be made in accordance with following provisions as established by Ohio Administrative Code section 3332-1-10:

1. A student who withdraws before the first class and after the 5-day cancellation period shall be obligated for the registration fee.
2. A student who starts class and withdraws before the academic term is 15% completed will be obligated for 25% of the tuition and refundable fees plus the registration fee.
3. A student who starts class and withdraws after the academic term is 15% but before the academic term is 25% completed will be obligated for 50% of the tuition and refundable fees plus the registration fee.
4. A student who starts class and withdraws after the academic term is 25% complete but before the academic term is 40% completed will be obligated for 75% of the tuition and refundable fees plus the registration fee.
5. A student who starts class and withdraws after the academic term is 40% completed will not be entitled to a refund of the tuition and fees.

American Institute of Health (AI-OH) shall make the appropriate refund within thirty days of the date the school is able to determine that a student has withdrawn or has been terminated from a program. Refunds shall be based upon the last date of a student's attendance or participation in an academic school activity.

Complaint or Grievance Procedure

All student complaints should be first directed to the school personnel involved. If no resolution is forthcoming, a written complaint shall be submitted to the director of the school. Whether or not the problem or complaint has been resolved to his/her satisfaction by the school, the student may direct any problem or complaint to the Executive Director, State Board of Career Colleges and Schools, 30 East Broad Street, Suite 2481, Columbus, Ohio, 43215, Phone 614-466-2752; toll free 877-275-4219.

I acknowledge that I have received a school catalog and agree with the school policies and procedure stated in the catalog. I acknowledge that I have received and read a copy of this enrollment agreement.

I acknowledge that I have received a school catalog and agree with the school policies and procedures stated. I acknowledge that I have received and read a copy of this enrollment agreement.

Applicant signature: ____ Date: ____________________

Parent or Guardian (if applicable): ________________________________ Date: ____________________

School Administrator: ____ Date: ____________________

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PHYSICAL EXAMINATION FORM

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PHYSICAL EXAMINATION FORM: Must be completed by a Physician, NURSING Practitioner or Physician's Assistant.

Last Name:	First Name:	MI:	SS#:
Allergies:			
Medications:			
EXAMINER: Indicate your findings after physical examination			
EENT:			
NEURO:			
CV:			
ENDOCRINE:			
MUSC/SKEL:			

☐ If this student is allergic to latex, please complete the portions of the "Latex Reaction Form: that the student will supply to you.
☐ If this is subject to any health emergency, please provide special emergency instruction below.
☐ If there is additional information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

Does this student have any functional limitation or restrictions that would prevent him/her from working in a patient care area?	Yes.	No.
Vision, such as reading gauge or thermometers?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom?		
Lifting up to 50 pounds?		
Ambulation/Standing for several hours?		
Ability to handle stress?		
Sensorimotor (fine and gross)?		

Does the student have any limitation or restriction? If no, please document below "No restrictions/No limitation". If yes, please provide specific facts regarding this student.

____

Signature of Examiner: ______________________________ Tel: ______________________________

Print Name: ______________________________ Date: ______________________________

Address: ____

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TUBERCULOSIS TEST

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Print Name: ____ Date: ______________________________

Address: ____

Tuberculosis Testing

Two-Step Mantoux (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, NURSING, or physician's assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.

Tb#1	**Tb#2** At **least 7 days after the first Tb test**:
Date given:___________	Date given:_____________
Date read:___________	Date read: _____________
Result:_____________mm	Result:________________mm
Read by:______________________	Read by: _________________________

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years.

FACILITY NAME: ____

ADDRESS: ____

TELEPHONE: ____ DATE: ______________________________