The Alverno Certified Nurse Aide Course
Summary Sheet of Skills Validation

Student's Name:_____

Total Number of Hours Student Attended During the Course:_____

Description: The following summary is a validation of the Certified Nurse Aide Student's level of competency included in the 75-hour course. The date indicates when the Certified Nurse Aide Student demonstrated this competency as a pass or fail.

Skills	Pass / date	Fail / date	Comments
1. Handwashing Technique			
2. Gloving – Putting on and Removing			
3. Closed and Open Bed			
4. Occupied Bed			
5. Conscious/Unconscious Choking Victim			
6. Lift and Move a Resident in Bed			
7. Transfer a Resident from bed to chair /chair to bed			
a. With a Gait Belt			
b. With a Mechanical Lift			
8. Ambulate with a Gait Belt			
9. Position a Resident in Bed			
10. Ambulate a Resident			
11. Passive Range of Motion			
12. Assist with Oral Hygiene			
a. Conscious Resident			
b. Denture Care			
c. Unconscious Resident			
13. Partial Bath			
14. Complete Bed Bath			
15. Whirlpool Bath			
16. Shower			
17. Back Rub			
18. Shampoo			
19. Nail Care			
20. Groom-Dress/Undress a Resident			
21. Shave a Resident with an Electric Razor			
22. Shave a Resident with a Razor			
23. Urinal for a Male Resident			
24. Assist with Bedpan/Commode			
25. Peri Care			
26. Vital Signs /Weight			
a. Proper Documentation			
27. Intake and Output			
a. Proper Documentation			

28. Catheter Care			
29. Safety Checks /Call light placement			
30. Feeding Assist with meals a. Understanding special diets			
31. Resident Privacy			
32. Use of Personal Protective Equipment			

Instructor Signature:_____

Date of Completion:_____

The Alverno Nurse Aide Clinical – Instructor evaluation of the Student

Student's Name:_____ Date Completed:_____

This evaluation is based on the student's competencies and objectives for the class. The student's performance will be assessed as follows:

1. Above Average 2. Average 3. Needs Improvement

Skills	1	2	3	Comments
A. Personal Characteristics				
1. Personal Appearance – well groomed, neat in appearance				
2. Dependability- On time, does not miss				
3. Cooperativeness – assists others when needed				
4. Guidance- uses suggestions to improve				
5. Ability to Learn- follows directions, open to learning new skills				
6. Initiative- able to solve some problems independently				
7. Judgement- makes good decisions, seeks help if needed				
8. Works Independently- can work without supervision				
9. Quality- Work is accurate and accomplishes what needs to be done timely				
B. Interpersonal Relationships with Residents				
1. Relationship- friendly, kind, compassionate, understanding				
2. Resident Safety-aware of resident surroundings, uses required safety equipment, answers call-lights promptly				
3. Provides residents with personal choices				
4. Cares for resident's personal property				
5. Communication- reports observations to the supervisory nurse as appropriate				

□ Pass □ Fail, needs more education

If student failed, provide more details:_____

_____

_____

_____

Instructor's Signature:_____ Date:_____

The Alverno Nurse Aide Clinical – Student Evaluation of the Instructor

Instructor's Name:_____ Date Completed:_____

This evaluation is based on the Instructor's ability to effective teach the Certified Nurse Aide Course.

1. Above Average 2. Average 3. Needs Improvement

Skills	1	2	3	Comments
1. Does the Instructor have accurate knowledge of the subject area				
2. Does the Instructor present material in ways that you understand				
3. Does the Instructor care about the needs of the students				
4. Does the Instructor speak clearly				
5. Does the Instructor promote a positive environment for learning				
6. Does the Instructor respond timely to concerns / questions				
Suggestions for the Instructor				
_____				
_____				
_____				
_____				
_____				

Student's Signature:_____ Date:_____

Long Term Care Program

STATEMENT OF UNDERSTANDING

I have been informed of the policies & requirements for successful completion of the Alverno Nurse Aide Program and for receiving a Certified Nurse Aide certificate. The Student handbook was reviewed during class orientation. I acknowledge that I have a clear understanding of the program policies and the consequences of policy infractions. Falsifying any signed documents will result in immediate and permanent dismissal from the program. I agree to abide by these policies stated in the Nurse Aide Handbook.

STATEMENT OF UNDERSTANDING: sign_____**Date**_____

WAIVER

I hereby release The Alverno, the Training Program, and/or Nurse Aide faculty/Nurse Aide Instructors from any illness or injury incurred as a result of participating in The Alverno Nurse Aide Program.

WAIVER: sign_____**Date**_____

HIPAA TRAINING

I have received and understand the information received concerning the Health Insurance Portability and Accountability Act of 1996 and the new standards adopted in May 2005. I have been informed The Alverno privacy and confidentiality policies and agree to abide by these policies as outlined in the Nurse Aide Handbook.

HIPAA TRAINING: sign_____**Date**_____

HEPATITIS B VACCINATION DECLINATION FORM

I understand due to my occupational exposure to blood or other potentially infectious materials during my clinical rotation that I may be at risk of acquiring the Hepatitis B virus (HBV) infection. The vaccination will be provided at my own expense if my insurance does not cover the cost. I understand that by declining this vaccine, I continue to be a risk of acquiring HBV. I hereby release The Alverno and my clinical agency of any responsibility if I should contract HBV while I am a student. I also understand declining the vaccination that certain clinical sites may not accept me as a student.

HEPATITIS B VACCINATION DECLINATION FORM:

Sign_____**Date**_____

PROTOCOL FOR PROHIBITION OF CHARGES FOR NURSE AIDE TRAINING AND TESTING

I have received and understand the information of Prohibition of Charges.

Sign_____**Date**_____

STUDENT RESPONSIBILITIES FORM

I have read and understand the information on the Student Responsibilities form.

Sign_____**Date**_____

Instructor Signature_____**Date**_____

THE ALVERNO CERTIFICATION OF COMPLETION OF 16 HOURS OF TRAINING

_____ (NAME OF TRAINEE) has completed the 16 hours of training in the following areas prior to any direct contact with residents:

1. Communication and interpersonal skills
2. Infection control
3. Safety/emergency procedures, including the Heimlich maneuver
4. Promoting residents' independence
5. Promoting residents' rights

Instructor Signature_____ Date:_____

Student Signature_____ Date:_____

THE ALCERNO

Clinton, Iowa

Certificate of Completion

This is to certify that

Has successfully completed 75 hours in Nurse Aide Class #_____ on _____,20

_____

Instructor

_____

Director of Nursing

_____

President/CEO

The Alverno Health Care Facility

Orientation Checklist

Class # _____

Class Title _____

Beginning Date _____ **Ending Date** _____

Hours _____

Instructor(s) _____

Student Name	Handbook Orientation	Statement of understanding	Waiver	HIPAA	Hepatitis B	Prohibition of Charges	Student Responsibility	Medical History	TB	Requirement for Success
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										

The Alverno Health Care Facility

Long Term Care
Seventy Five Hour Nurse Aide Training Program

Requirement for Successful course Completion

1. Academics: Average of 80% on Quizzes, Skills Lab, and Final Exam.

2. Skills Competencies: Hand Hygiene, Gloving, choking, and Patient's Rights must be performed at a level 4 to be eligible for Clinical Rotation.

3. Successful completion of Clinical Rotation.

4. If all areas listed above are completed successfully, you will be awarded a certificate of completion as a Nurse Aide The Alverno Health Care Facility.

I have read and understand all requirements necessary for successful course completion of the Certified Nurse Aide Program through The Alverno Health Care Facility.

_____ _____

Student Name (Print) Date

_____ _____

Student Signature Date

_____ _____

NA Instructor Date

_____ _____

LTC Coordinator/Director Date

STATE OF IOWA
Criminal History Record Check
Request Form

DCI Account Number: _____
(if applicable)

To: **Iowa Division of Criminal Investigation**
Support Operations Bureau, 1st Floor
215 E. 7th Street
Des Moines, Iowa 50319
(515) 725-6066
(515) 725-6080 Fax

From: _____

_____

_____

Phone: _____

Fax: _____

I am requesting an Iowa Criminal History Record Check on:

Last Name (mandatory)	**First Name** (mandatory)	**Middle Name** (recommended)
Date of Birth (mandatory)	**Gender** (mandatory)	**Social Security Number** (recommended)
	☐ Male ☐ Female	

Waiver Information: **Without a signed waiver from the subject of the request, a complete criminal history record may not be releasable, per Code of Iowa, Chapter 692.2. For complete criminal history record information, as allowed by law, always obtain a waiver signature from the subject of the request.**

Waiver Release: I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation (DCI). Any criminal history data concerning me that is maintained by the DCI may be released as allowed by law.

Waiver Signature: _____

Iowa Criminal History Record Check Results

(DCI use only)

As of _____, a search of the provided name and date of birth revealed:

☐ No Iowa Criminal History Record found with DCI

☐ Iowa Criminal History Record attached, DCI #_____

DCI initials_____

DCI-77 (08/25/10)

THE ALVERNO

EMPLOYMENT APPLICATION ADDENDUM

Name: _____

Address: _____

Home Telephone: _____ Cell Telephone: _____

Date of Birth: _____ Social Security Number: _____

Professional License No.: _____

Position applying for: _____

Provide all other names or aliases you have ever previously been known by, including but not limited to nicknames, maiden names and other married names:

_____

_____

_____

Do you have knowledge, or have you ever been notified, of being placed on the OIG Excluded Provider List or Excluded Parties List Service (EPLS.gov) maintained by the General Services Administration (GSA)? If yes, please specify the date and reason. (Even if you were at one time on such list and have since been removed, please so indicate):

_____

_____

Have you ever had a professional license subject to suspension or revocation? If yes, please specify the date and the reason:

_____

_____

Have you ever voluntarily relinquished your professional license? If yes, please specify the date and reason:

_____

_____

PLEASE READ CAREFULLY BEFORE SIGNING:

I certify that the above answers given are true and complete to the best of my knowledge. I understand that the Facility may investigate all statements made in this Application and that any false or misleading information provided can result in a decision not to hire; immediate discharge if hired, and civil or criminal penalties as appropriate. I further understand that this Addendum is considered part of the original Application for Employment and shall be incorporated therein.

_____ _____

Signature Date