Sparta High School Student Services

506 N. Black River Street, Sparta, WI 54656 Phone: (608) 366-3425 Fax: (608) 366-3507

Dear Student,

Please submit the following paperwork required for you to take the Nursing Assistant course at Western Technical College. Keep in mind the course is extremely competitive and spaces are limited, all forms must be received by March 1st for Fall Semester courses and October 1st for Spring Semester courses.

____ Completed Start College Now application (with valid email address)

____ Testing scores submitted to Western

- ____ ACT (English: 19, Math: 22, Reading: 22) unofficial score reports are accepted
- ____ Accuplacer (schedule online at www.westerntc.edu/schedule-your-test)

____ Western Health Immunization Form (signed by Healthcare provided, two pages)

- ____ MMR, Hepatitis B, Varicella, and Tetanus Vaccines
- ____ 2 Step TB Skin Test (7-10 days apart)

____ Nursing Assistant Background Check (BID) Form (signed and completed)

____ Nursing Assistant Essential Functions Form (signed and completed)

Once the forms are complete they will be sent, along with your high school transcript, to Western Technical College for their approval. Students will receive all communication about the class through the email account provided or mailed directly to their home from Western Technical College. Students must read all information carefully. **Enrollment is not guaranteed – there are a limited number of spaces and many applicants for each course.** If you are able to gain a spot in a course the school district will pay for your tuition and books (books will be mailed to the school prior to the start of your course, do not buy them at the Western bookstore as you will not be reimbursed). Students are responsible for their uniform, the state licensing exam fee, and their transportation to and from the course. If you have any questions, please speak with your high school counselor.

Thank you,

Chrissy DeLong

Chrissy DeLong
Sparta High School Counselor
cdelong@spartan.org

HEALTH IMMUNIZATION FORM
Western Technical College (revised Feb 2018)

- **THIS FORM MUST BE SIGNED BY A HEALTHCARE PROFESSIONAL (PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, NURSE OR MEDICAL ASSISTANT).**
- **NURSING ASSISTANT STUDENTS ARE ONLY REQUIRED TO COMPLETE THE TUBERCULOSIS (TB) SKIN TEST.**
- **All other health/education programs are required to complete the entire form. Understand that the clinical sites or other agencies may require additional immunizations or titers. You will be contacted if this applies to your placement.**

Western uses the current Center for Disease Control and Prevention (CDC) guidelines to determine the acceptability of documentation for proof of immunization.

PATIENT INFORMATION

NAME_____ DATE OF BIRTH _____PROGRAM_____

MMR VACCINE
(MEASLES (RUBEOLA) / MUMPS / RUBELLA)

Date of Vaccines #1_____

#2_____

OR

Dates of Titer

Measles (Rubeola) Titer _____
Immune / Non-Immune

Mumps Titer _____
Immune / Non-Immune

Rubella Titer_____
Immune / Non-Immune

If born before 1957:

a) Proof of immunity for Measles, Mumps & Rubella via documentation of disease in medical record or titres
b) 2 doses of vaccine to satisfy requirements for Measles; 2 doses of vaccine to satisfy requirements for Mumps; 1 dose of vaccine to satisfy requirement for Rubella

TB SKIN TEST (required annually)

Two consecutive annual tests between 10 and 12 months apart. Please note that the second test *must not exceed 365 days from when the last one was administered*.

Current Year Read Date: _____ Initials _____
Negative / Positive

Previous Year Read Date: _____ Initials_____
Negative / Positive

If you do not have 2 consecutive current skin tests, a two-step is needed. ***Test dates must be 7-21 days apart.***

Step 1 Test Date: _____ Read Date_____

Step 1 Results:_____Negative/Positive _____Initials

Step 2 Test Date:_____ Read Date_____

Step 2 Results: _____Negative/Positive _____Initials

If you have a positive TB test or have a documented history of a positive TB test:

- *A negative chest x-ray report must be provided*
- *You must provide annual documentation that you are fee of communicable disease*
- *Contact Enrollment Services at 608.789.6138 for special instructions*

If your chest x-ray is positive for TB, proof of treatment is required.

_____ _____

Signature of Healthcare Provider **Printed Name and Title** **Date**

SUBMIT ALL DOCUMENTATION TO: Western Technical College, Enrollment Services-Student Immunization Records,
400 Seventh Street North, PO Box C-0908, La Crosse WI 54602-0908
Fax 608-785-9148For questions ca11608-785-9200 or 1-800-322-9982, ext.59553

HEALTH IMMUNIZATION FORM
Western Technical College (revised Feb 2018)

TO THE STUDENT:
All programs have affiliation agreements with agencies which require verification of compliance with the employee health standards. In many programs, these experiences begin within the first two weeks of school.

The form (BOTH SIDES) must be filled out completely.

PLEASE KEEP A COPY OF THIS RECORD FOR YOUR FILES.

Name_____

(Previous Name)_____

Address_____

_____

Student ID or SS # _____

Program Title _____

Date of Birth _____

Phone (Day) _____(eve)_____

HEPATITIS B VACCINE

Date of Vaccines

#1_____ #2_____ #3_____

OR

Hepatitis B Titer_____ Immune / Non-Immune
(*Attach copies of lab results*) (Circle one)

OR

Signed Declination Statement below:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I decline the vaccination at this time. I understand that by declining the Hepatitis B vaccine I continue to be at risk of acquiring Hepatitis B as a serious disease. 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 receive the vaccination series at that time.

_____
Student Signature Date

VARICELLA (CHICKEN POX)

Date of Vaccines #1_____ #2_____

OR

Varicella Titer _____ Immune / Non-Immune
(*Attach copies of lab results*) (Circle one)

OR

Verified history of Chicken Pox Disease

If yes, Date: _____

TETANUS / DIPHTHERIA (TD)

OR

TETANUS,DIPHTHERIA,ACCELLULAR PERTUSSIS (TDaP)

TD or TDaP is required every 10 years

Date _____ TD / TDaP (circle one)

_____
Signature of Healthcare Provider

_____
Printed Name and Title **Date**

SUBMIT ALL DOCUMENTATION TO: Western Technical College, Enrollment Services-Student Immunization Records,
400 Seventh Street North, PO Box C-0908, La Crosse WI 54602-0908
Fax 608-785-9148For questions ca11608-785-9200 or 1-800-322-9982, ext.59553

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (09/2017)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

For Instructions, see F-82064A.

Completion of this form is required under the provisions of Chapters 48.685 and 50.065, Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification, or registration; or denial or termination of your employment or contract. Refer to the instructions (F-82064A) on page 1 for additional information. Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.

PLEASE PRINT OR TYPE YOUR ANSWERS.

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Applicant for a license or certification or registration (including continuation or renewal)
☐ Household member / lives on premises – but not a client
☐ Other – Specify:

NOTE: If you are an owner, operator, board member, or non-client resident of a Division of Quality Assurance (DQA) facility, complete the BID, F-82064, and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Name – (First and Middle)	Name – (Last)

Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)

Any Other Names By Which You Have Been Known (Including Maiden Name)	Birth Date	Gender (M / F)

Race
☐ American Indian or Alaskan Native ☐ Black ☐ Unknown
☐ Asian or Pacific Islander ☐ White

Social Security Number(s)

Home Address	City	State	Zip Code

Prior Residence for Past Seven Years

1 – Address		2 – Address	
From	To	From	To
3 – Address		**4 – Address**	
From	To	From	To

Business Name and Address – Employer or Care Provider (Entity)

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION	YES	NO
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? ➢ If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10th birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.) ➢ If **Yes,** list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.	☐	☐
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: ❑ (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.) ➢ If **Yes**, explain, including when and where it happened.	☐	☐

Last Name –

DEPARTMENT OF HEALTH SERVICES
Division of Enterprise Services
F-82064 (09/2017)

STATE OF WISCONSIN
Chapters 48.685 and 50.065, Wis. Stats.
DHS 12.05(4), Wis. Admin. Code

BACKGROUND INFORMATION DISCLOSURE (BID)

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? ➢ If **Yes**, explain, including when and where it happened.	☐	☐
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? ➢ If **Yes**, explain, including credential name, limitations or restrictions, and time period.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION	**YES**	**NO**
1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? ➢ If **Yes,** explain, including when and where it happened.	☐	☐
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➢ If **Yes,** explain, including when and where it happened and the reason.	☐	☐
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➢ If yes, indicate the year of discharge: _____ ➢ Attach a copy of your DD214 if you were discharged within the last 3 years.	☐	☐
4. Have you resided outside of Wisconsin in the last 3 years? ➢ If **Yes**, list each state and the dates you lived there.	☐	☐
5. Have you had a caregiver background check done within the last 4 years? ➢ If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.	☐	☐
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS designated tribe? ➢ If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.	☐	☐

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to $1,000.00 and other sanctions as provided in DHS 12.05 (4), Wis. Adm. Code.

SIGNATURE	Date Signed

Western Technical College

Nursing Assistant Program
Functional Ability Criteria

The Nursing Assistant Program is highly regulated by state and federal law. OBRA, 1987 and State of Wisconsin, DHS 129, 2009 offer specific criteria for how the program will be run, what is taught, how it is taught, mandated hours needed to be completed and ability of the nurse aide to do the work required. Also, it is the intent of Western Technical College to fully comply with Section 504 of the Rehabilitation Act of 1974 and the Americans with Disabilities Act (ADA) of 1990. (In accordance with the ADA and Section 504, Western Technical College does not provide students with personal devices and services.)

In order to assist students to successfully complete the Nursing Assistant Program and achieve certification to work through the State of Wisconsin Caregiver Program, Western Technical College has developed a set of objective functional ability criteria.

Students will be asked to sign a form stating whether or not they are able to meet the functional abilities, with or without accommodations, as stated in this document. **If a student enters the Nursing Assistant Program on falsification of records related to their ability to meet functional requirements, he/she may face disciplinary action.** All documents will be kept on file with the Nursing Assistant instructor at the College.

For students with a disability, reasonable accommodations are available. Reasonable accommodations are defined as modifications or adjustments that allow individuals with disabilities to gain equal access and have equal opportunities to participate in Western Technical College courses, services, activities and use of the facilities. To be eligible for disability-related services/accommodations, students must have a documented disability. This documentation must be provided by a licensed professional, qualified in the appropriate specialty area. Western Technical College is not obliged to provide an accommodation that requires a substantial change in the curriculum or alteration of an essential element or functions of a program/course. Western Technical College is also not obligated to provide an accommodation that posts an undue financial or administrative burden to the College or poses a direct threat to the health and/or safety of others.

In accordance with ADA and Section 504 requirements, special accommodation requests require the approval of the nurse aide training program chair, the disabilities specialist and the DHS Office of Caregiver Quality. All requests for special accommodations must be approved before a student has enrolled in the program. The prospective student must provide documented proof of the need for the special accommodation. Any accommodation cannot substantially alter the requirements or nature of the program or inflict an undue burden on the program and/or clinical sites.

Accommodations allowed, without disability documentation: supportive back brace or other supportive brace that does not impede required movement or interfere with infection control policies, hearing aids, glasses, and/or contacts. Other student-suggested accommodations will require the approval of the Program chair, the Disabilities Specialist, and the Department of Health Services. All requests should be approved before the student has enrolled in the program. Any accommodation cannot substantially alter the requirements or nature of the program or provide accommodations that inflict an undue burden on the respective program and clinical sites.

If you are a person with a documented disability and would like to request accommodations, please contact Kristina Stellpflug, email Stellpflugk@westerntc.edu or (608) 785-9875 in Disabilities Services. It is required that you contact them at least three weeks prior to the start of the course so an accommodation plan can be made.

The following is a list of functional abilities the student must have in order to participate in the Nursing Assistant Program at Western Technical College.

GROSS MOTOR SKILLS:
Ability to move in confined spaces, maintain balance in standing position, move body from one side to the other, reach below the waist and to the front of the side of the body to the level of the top of head (examples: adjust overhead lights, plug electrical appliance into wall outlet)

Ability to push, pull, stabilize, and freely move arms to allow movement of 50 pounds as in moving an object or transferring a client from one place to another

FINE MOTOR SKILLS:
Ability to grasp, twist, squeeze, pinch, and manipulate fire equipment for at least 5 seconds (example: operate fire extinguishers)

Ability for eye-hand and eye-hand-foot coordination

TACTILE ABILITY:
Ability to distinguish subtle vibrations through the skin (pulse)

Ability to identify the subtle difference in surface characteristics (feel a raised rash)

Ability to detect temperature (skin, liquids, environment)

MOBILITY:
Ability to squat or modified squat (one knee on floor) for at least one minute

Ability to move quickly in case of emergency situations

Ability to climb and descent a flight of stairs

Ability to walk independently without the assistance of a cane, walker, crutches, wheelchair or the assistance of another person

ENVIRONMENT & PHYSICAL ENDURANCE:
Ability to have stamina sufficient to maintain physical activity for a period of time from 5 – 8 hours

Ability to tolerate exposure to common allergens such as pets, body lotions and soaps, cleaning products

- Student must inform Nursing Assistant Instructor **in advance** of class to assess if a pet resides in the clinical environment, attempts will be made to place student in a clinical site without a pet.

Ability to tolerate working in confined areas

Ability to work indoors for five to eight hours

Ability to tolerate exposure to slippery or uneven walking surfaces

Ability to be able to wear safety glasses, face shield, face mask and other protective clothing

Ability to tolerate heat and humidity as high as 90 degrees for up to ½ hour (shower and spa rooms)
SPEECH AND COMMUNICATION:

Ability to interact with others to report observations and advocate for the needs of clients

Ability to speak, write and understand English in order to be able to communicate with clients as well as report and document client information

SENSES: SMELL, HEARING AND VISION:
Ability to detect differences in body and environmental odors

Ability to hear and understand voices spoken at a normal speaking volume at a distance of 10 feet (typical length of a room) (example: person to person conversation or telephone conversation)

Ability to hear faint noises such as whispers within a range of 4 feet (considered the typical comfort zone)

Ability to see objects clearly within a minimum of 20 feet

Ability to have depth perception and peripheral vision to allow identification of dangerous objects and client situations within the client room

Ability to read and interpret written data held at a reasonable distance

EMOTIONAL STABILITY:
Ability to interact and support clients during times of stress and emotional upset

Ability to adapt to changing situations and emergency conditions while maintaining emotional control

Ability to cope with strong emotions and physical outbursts of clients while remaining in a reasonable state of calm

Ability to focus attention on client needs despite interruptions and multiple demands

Ability to accept constructive feedback and accept responsibility for own actions

INTERPERSONAL SKILLS:
Ability to apply knowledge gained in classroom to establish appropriate relationships with clients, families and coworkers

Ability to interact as a member of the health care team

Ability to show respect for diversity in culture, religion, sexual orientation, marital status, socio-economic status and abilities/disabilities

READING:
Ability to read and understand at a minimum of an 8^{th} grade level with ability to understand charts, graphs and worksheets

- Students with reading levels below grade 8 are required to complete concurrently the Applied Reading for the Nursing Assistant course.

Ability to read and understand digital and computer displays

MATH:

Ability to do basic math including add, subtract, multiply, and divide **without** the use of a calculator

Ability to count and understand the meaning of numbers

Ability to measure length by reading a tape measure or ruler

Ability to tell time on a clock

COGNITIVE/MENTAL FACTORS:

Ability to deal with abstract and concrete variables, define problems, collect and coordinate data, establish facts, and draw valid conclusions

Ability to perceive pertinent detail in objects or in pictorial or graphic material

Ability to comprehend and follow instructions

Ability to perform simple and repetitive tasks

Ability to relate to other people beyond giving and receiving instructions

Ability to influence people

Ability to perform complex or varied tasks

Ability to make generalizations, evaluations or decisions without immediate supervision

Ability to accept and carry out responsibility for direction, control and planning

Nursing Assistant Program
Functional Ability Criteria
Statement of Understanding

The Americans with Disabilities Act of 1990 (42 U.S.C. & 12101 *et seq.*) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. & 794) prohibits discrimination of persons because of his/her disability. In keeping with these laws, colleges of the Wisconsin Technical College System make every effort to ensure a quality education for students. The purpose of this document is to ensure that students acknowledge that they have been provided information on the functional abilities required of a student in the Nursing Assistant Program.

Please complete this form and return to Registration along with the application, background form and immunization records.

_____ (initials/date) I have read, understand, and can meet the *Functional Ability Criteria* specific to a student in the Nursing Assistant Program.

_____ (initials/date) I am unable to meet the Functional Ability Criteria presented and am requesting accommodations at this time (please complete page 6)

_____ Name of Student (please print)

_____ Student ID#, SS#, or DOB

_____ Signature of Student

_____ Date

Return to:
Western Technical College
Attn: Admission
400 7th Street North
PO Box C-0908
La Crosse, WI 54602
(608) 785-9553
Fax (608) 785-9148

Western Technical College
Accommodation Request Form for Students with Disabilities

Complete this form only if you require accommodations. It is the intent of Western Technical College to fully comply with Section 504 of the Rehabilitation Act of 1974 and the Americans with Disabilities Act (ADA) of 1990. In accordance with ADA and Section 504, Western Technical College does not provide students with personal devices and services.

Requests for accommodations are based on mutual planning among Disabilities Services, Student Services, and Nursing Assistant Instructors and/or Associate Deans.

Date: _____ Student ID, SS# or DOB _____
Name: _____
Address: _____

Need for accommodation: _____
_____
_____
_____

Documentation of disability (please attach):

Requester's suggested accommodation: _____
_____
_____
_____

Suggested accommodation by DVR, other agency or individual: _____
_____
_____
_____

Western Technical College accommodation plan: _____
_____
_____
_____

Request received by: _____ Date: _____

Return to:
Western Technical College
Attn: Admission
400 7th Street North
PO Box C-0908
La Crosse, WI 54602
(608) 785-9553
Fax (608) 785-9148

Reviewed 10/2015