BRADFORD
CAREER CENTER

2522 Grand Canal Blvd. Suite 12 & 13
Stockton, CA. 95207
Phone: (209) 475-9854 Fax: (209) 475-9864

Part I: To be completed by Student: Indicate program of application:
Nursing Assistant/Home Health Assistant
Vocational Nursing

Applicant information:			
Last Name	First Name	MI	Maiden
Address	City	State	Zip
email	Birth date	Gender M / F	
Phone (day)	Phone (eve)	Phone (cell)	

Person to notify in case of emergency:			
Full Name:	Relationship:		
Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell:	

HEALTH HISTORY

Please rate you current health status: Excellent Good Fair Poor
Certain minimum physical abilities and characteristics are required in health sciences professions. See attached for specific requirements. Do you have any condition that would interfere with your ability to perform the minimum technical skills standards for the program to which you are applying? Yes No If yes, explain: _____
Are you pregnant? Yes No Due date: _____
Allergies/sensitivities (i.e. medications, foods, Latex/Powder): Please List: _____
Do you have any lifting restrictions: Yes No If yes, explain: _____

Part II: To be completed by health care provider.

The information provided is true and correct to the best of my knowledge. I am aware that any change in my physical or mental health, including pregnancy, during the program may require that I obtain medical clearance to continue in the program.
Student Signature: Date:

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Applicant Name:	Date:

Height:_____ Weight:_____ Hearing Test Results:_____

Pulse:_____ /Minute_____ RE/IRR _____

Blood Pressure: _____Visual Acuity: Right Eye: _____Left Eye _____

Identify any health conditions in the following:			
Head, ears, nose, throat	Yes or No	Gastrointestinal	Yes or No
Eyes	Yes or No	Genitourinary (by report)	Yes or No
Respiratory	Yes or No	Musculoskeletal	Yes or No
Cardiovascular	Yes or No	Neurological	Yes or No
Hernia	Yes or No	Skin	Yes or No

If health conditions are present, do they create a limitation in the ability to provide health care?
Yes **or** No
If yes, please explain:

Hepatitis B: must show proof of:

A. Three doses of vaccine administered over a period of 4-6 months. Minimum timeline: Second dose 4 weeks after initial dose and 3rd dose 8 weeks after second with at lease 16 weeks after first **OR**

Date # 1_____
Date # 2_____
Date # 3_____

B. Serologic titer positive for Hepatitis B antibody (at least 10 mIU/mL)

Date: _____
Result:_____

C. Hepatitis B Waiver: _____

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Tuberculosis Screening (annual while participating in program):
Must show proof of:

A. Two Negative PPD results within a 12- month time frame. 2nd PPD must be within 6 months of starting program **OR**

Date # 1_____ Result:_____
Date # 2_____ Result:_____

B. If PPD is positive or there is a history of positive PPD, there must be a record of a negative chest X-ray within past 2 years and a TB screening questionnaire must be complete **OR**

Date:_____ Result:_____

C. If had a previous BCG vaccine - may opt for results of a Quantiferon TB Gold titer instead of chest xray. (Blood test that requires physician order)

Date:_____ Result:_____

CPR Certification must show proof of current certification in:

Basic Life Support (BLS) for the Healthcare Professional including Adult, Child & Infant Resuscitation and two-person rescue.

Expiration Date: _____

For Health Sciences Division Use Only:

Date Received:

Immunization official documentation verified by: