QMA PRE-ADMISSION CHECKLIST

Due Date	What	Who	In Progress	Done
All documents are due day 1 of class	Copy of Indiana CNA certification	Employer/ student		
	Copy of TB test-with the year Physical- last 12 months Background Check- last 30 days, no felonies last 5 years	Employer/ student		
	Copy of photo ID for age verification	Student		
	QMA Program Application	Student		
	Math and English tests Prior to the start of class, must score 80% or higher	Student		
	Official copy of Highschool or equivalency diploma	Student		
	CNA hours verification (filled out by employer, see attached form)	Employer		
	Letter of agreement from employer stating availability to complete clinicals	Employer / Student		

NOTES:

All items are required prior to the 1st day of class. If you are having issues with anything, please reach out to me so I can help you. DO NOT WAIT UNTIL THE LAST MINUTE TO TRY TO GET ALL OF THIS TOGETHER!

Failure to complete checklist will forfeit your place in the class, you will have to start the next class.

Kaiser Healthcare Certification LLC

Student Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Emergency Contacts

Please list emergency contacts.

Full Name: _____ Relationship: _____

Phone: _____ _____

Address: _____

Full Name: _____ Relationship: _____

Phone: _____ _____

Address: _____

Full Name: _____ Relationship: _____

Phone: _____ _____

Address: _____

Health Information

Have you ever tested positive for Tuberculosis? _____ YES _____ NO

Date of last PPD: _____

Where was PPD received? _____

Please provide a copy of the you TB screening, chest x-ray, or PPD record prior to the end of the program.

Kaiser Healthcare Certification LLC Training and Testing Policies

Privacy Policy: We do not give out any information about a student to anyone except a state agency or as required by law.

Attendance Policy: You MUST attend all training dates as scheduled. You must be on time for both classroom and clinical hours. There will be no scheduled make-up days unless preapproved by the instructor.

TB skin testing and chest X-ray Policy: You must receive a TB skin test or chest X-ray before the start of the class. If you have a positive TB skin test, you must get a chest x-ray to rule out TB prior to any classroom hours. Your employer will obtain these. If you are not employed, it will be at your expense.

Student Removal Policy: The Program Director has the right, along with the clinical site, to remove a student from the program at any time. Reasons for removal include but are not limited to disrespect to the instructors, other students, or anyone involved in the training process. Abuse and/or Neglect of a resident, Cursing/Swearing, not abiding by the rules, tardiness, or truancy. Please stay professional; this is the start of your career in healthcare, and your attitude matters.

Refund Policy: There will be no refunds given once a student arrives for the 1st day of class, as there has already been an investment made in the form of rent, materials, and insurance for each student.

I affirm and attest that I understand in full the aforementioned policies and procedures.

X_____ Date:_____

Kaiser Healthcare Certification Training Program Guidelines

1. Attendance is mandatory. Students are expected to be present and on time for all classes and clinical assignments. Only true emergencies should prevent the student from being present and on time to class. A phone call to the program director (Lex Ann Kaiser 812-972-2769) must be made prior to the start of class to discuss the possibility of make up time. Make up time is at the discretion of the program director only!
2. Attire for the classroom is casual. However, there will be no shorts, tank tops, tube tops, etc. Closed toed shoes are to be worn to class. For clinicals: the student mut wear scrubs or uniform dictated by the clinical site. Clothing should be clean and wrinkle free. The student should be clean and well-groomed for both class and clinicals.
3. No cell phones should be visible during classroom time. No ear buds or air pods are to be worn in the classroom or skills lab.
4. Students should refrain from crude, vulgar or profane language.
5. Students will not come to class or clinical under the influence of alcohol, illegal drugs, or medications that cause side effects that pose a risk to the safe performance of their duties.
6. Students are expected to do all class assignments, homework assignments, read the text and commit vocabulary terms to memory.
7. All class and clinical requirements must be met prior to the Program Director submitting an application for state testing. Tuition pays for the 1st attempt; the student is responsible to pay for the 2nd and/or 3rd if necessary.
8. Students are expected to be respectful in the class and clinical setting. We all learn differently and different rates, some will have more questions than others. Verbal and nonverbal communication should reflect respect and tolerance toward one another, the instructor, staff and residents.
9. Students must have a working phone number during the duration of the course. It is up to the student to update information in the event of a change. The Program Director will need to communicate with students throughout the training process regarding progress, schedule changes etc.
10. Smoking is only permitted in designated areas. Please be respectful, keeping away from entrances and picking up trash and cigarette butts.

11. Refund policy: There are no refunds once a student arrives for day 1 of the course as the Program Director as already made a great investment in each student in the form of supplies, rent, insurance etc.
12. Students must arrive to the 1st day of class with all required paperwork (failure to do so will result in removal from the class) background check, PPd, physical, clinical agreement.

I have read the above guidelines and agree to follow them while participating in the training program. I understand that failure to meet the above guidelines will result in termination from the program.

STUDENT:_____
DATE:_____

FACILITY REPRESENTIVE:_____
DATE:_____

PROGRAM DIRCTOR:_____
DATE:_____

Kaiser Healthcare Certification LLC

Payment Agreement

I understand and agree that I am financially responsible for payment of the services received by Kaiser Healthcare Certification LLC in the amount stated below. I agree to pay the amount in the time period stated below.

I understand that there will be NO refunds issued, NO EXCEPTIONS.

I understand that any remaining balance not paid in full will accrue a monthly service charge of $25.00.

I understand that all credit/debit/online payments will be assessed a service fee of 3.5%.

For professional services rendered, QMA Program, I agree to pay Kaiser Healthcare Certification LLC the total sum of $1,200.00.

STUDENT NAME: _____

DEPSOIT AMOUNT: _____

PAYMENT AMOUNT: _____ ***WEEKLY/BI-WEEKLY***

FINAL PAYMENT DUE DATE: _____

I understand that I will be unable to take the certification exam until payment is received in full.

STUDENT SIGNATURE/DATE: _____

PROGRAM DIRECTOR SIGNATURE: _____

For students who are receiving sponsorship by their employer

1. ***You are obligated to adhere to any agreement you make with your facility. Pay, days worked, etc., are between the student and the employer. If you quit and they require repayment the balance is the responsibility of the student.***
2. ***A facility representative (Administrator, DNS, HR manager, Business office manager) MUST sign agreeing to pay tuition or the student will receive an invoice at the start of class.***

By signing the student and the facility agree to the terms of this payment agreement.

STUDENT SIGNATURE: _____

FACILITY REPRESENTITIVE SIGNATURE, TITLE AND DATE:

_____

ISDH QMA 40 Hour Practicum Agreement Between Kaiser Healthcare and Student's Facility

Student's Name: _____ Class Date: _____

_____

(Facility Name and Corporate Name)

is an approved site for conducting the ISDH QMA 40 Hour Practicum **under the direct supervision of a designated licensed nurse at the student's above-named facility - the student must perform these 50 procedures with 100% accuracy.**

The student needs written permission from the Director of Nursing or designee that allows the QMA student to complete the 40-hour practicum requirement at their facility. The QMA student **MUST** perform as many procedures as possible that are available in the **ENTIRE** facility. The practicum is their hands-on experience to complete the 100-hour ISDH QMA Program. Please contact Lex Ann Kaiser for any clarifications or questions regarding this.

Facility Contact Name: _____ Email _____ Phone: _____

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND I ACCEPT AND AGREE TO CONTACT LEX ANN KAISER IF THE STUDENT IS NOT ABLE TO COMPLETE THE COMPETENCIES TRAINING AT THIS FACILITY.
PLEASE NOTIFY ME ASAP AT LEX.ANN@KAISERHEALTHCARECERTIFICATIONS.COM

_____ _____
Signature of Director of Nursing or Administration Date

_____
Printed Name and Title (Director of Nursing or Administrator)

_____
Lex Ann Kaiser RN/Program Director

Lex Ann Kaiser, RN
CNA/QMA Program Director
Phone: (812) 972-2769
Email: lex.ann@kaiserhealthcarecertifications.com

C.N.A. Pre-Registry Check

Student name:

Address: Required

Are you currently or have you ever been on the state registry in Indiana or in any other state for a license or certification? Examples would be C.N.A., H.H.A., Cosmetology, Bartender, Notary Public, Pharmacy Tech etc.

YES NO

If you answered yes:

Type of license or certification:

State it was held in?

What name was it held in?

Did you have any disciplinary findings against you? If so, please list.

Student Signature:

Pre-registry verification by_____Date_____

Section 1: Verification of Work Experience

I, _____, a representative of _____
(print your name) (name of facility)

verify that _____ has completed at least 1,000 hours* of work
(name of QMA applicant)

experience as a certified nurse aide during the past two (2) years.

Facility Representative Name & Title: _____

Date: _____

Email Address: _____ Phone Number: _____

*If applicant's work experience is less than 1,000 hours at one facility, indicate the number of hours completed at your facility. It is the responsibility of the applicant to submit verification forms from all facilities where the 1,000 hours were obtained.

Section 2: Verification of Nurse Aide Registry Status

State: _____ Date Verified: _____

Listed on Registry? _____ Yes _____ No

CNA Expiration Date: _____

Confirmed Finding(s)? _____ Yes _____ No

If yes, describe:

_____

_____

_____

_____

_____

Signature & Title of Individual Obtaining Information: _____

Date: _____

Photo Release Form

I, the undersigned, give authorization for Kaiser Healthcare Certification LLC to use my photograph on Facebook, Instagram, LinkedIn, and the website (kaiserhealthcarecertifications.com)

I understand that my name will not be used without consent.

Student Name: _____

Student Signature: _____

Date: _____

Background Check Information and Consent

Kaiser Healthcare Certification LLC will conduct a state background check through the Indiana State Police. This information is shared with you and kept on your student file as required by Indiana State Department of Health. If you have had a felony of any kind or a misdemeanor in the areas of theft, abuse (violent crimes) drug use in the previous 5 years you are not eligible for the CNA/QMA program per state regulations.

Student First Name: _____

Middle Initial: _____

Last Name: _____

Married Name 1: _____

Married Name 2: _____

Maiden Name: _____

Any other names: _____

Country of Birth: _____

State of Birth: _____

Date of Birth: _____

Race: _____

Gender: Male or Female

Social Security Number: _____

By signing you authorize Kaiser Healthcare Certification to obtain a criminal background check. You understand that you are responsible for the fee of $16.00.

Student signature

X _____ ***Date:*** _____

Lex Ann Kaiser RN/Program Director

X _____ ***Date:*** _____

Background Check conducted: Date: _____ ***Initials:*** _____

Background Check Verified: Date: _____ ***Initials:*** _____

Student Physical

Name_____

D.O.B._____

Ht_____ Wt_____ Temp____ P_____ R_____ BP_____

Allergies _____

Current Medications

_____

_____

Medical Problems_____

Past Surgeries_____

√ = Normal

Head_____

EENT_____

Chest_____Heart_____

Extremities_____Abdomen_____

G.I. Tract_____G.U. Tract_____

I certify that this student can participate without restrictions in the clinical portion of the program.

Date_____Physician Signature_____

QMA Applicant Name: _____ Date: _____

Mathematical Function Evaluation

Complete the following equations without the use of a calculator:

1.) 25 X5

2.) 32 X6

3.) 125 +215

4.) 450 -125

5.) 45 ÷ 9 = _____

6.) 325 X2

7.) 240 ÷ 6 = _____

8.) 8 X8

9.) 150 ÷ 5 = _____

10.) 632 - 120

11.) 3 X2

12.) 10 - 7

13.) 18 X3

14.) 24 +12

15.) 125 ÷ 5 = _____

16.) 60 +45

17.) 30 ÷ 3 = _____

18.) 35 +25

19.) 36 -12

20.) 66 ÷ 11 = _____

21) 40 -12

22.) 45 ÷ 5 = _____

23.) 66 -16

24.) 66 +34

25.) 88 -11

26.) 40 +20

27.) 68 -14

28.) 10 X5

29.) 60 ÷ 3 = _____

30.) 14 X2

31.) 4 +8

32.) 26 - 18

33.) 36 ÷ 6 = _____

34.) 24 X2

QMA Applicant Name_____ Date_____

English Comprehension Evaluation

Directions: Read the following paragraph aloud.

I am a new employee serving as a caregiver in a long term care facility. While I am walking down the hall during my first week of work, I see that a call light is ringing from a resident's room. Although this is not my assigned resident and I do not know the resident very well, I wonder if I should stop and ask how I can assist the resident. I decide that I will stop, and so I enter the room of Mrs. Smith. When I ask what I can do to assist Mrs. Smith, she informs me that she would like a drink of water from her bedside pitcher. She also wants to be transferred from the bed to her recliner because she is very uncomfortable. She complains of pain in her back and demands to speak with the nurse right away.

Discussion Questions:

1. What would you do first to assist Mrs. Smith?

2. What would you need to do prior to attempting to transfer Mrs. Smith to the recliner?

3. What might you ask Mrs. Smith about her pain in an effort to report to the nurse the concerns of Mrs. Smith?

Comments: _____

_____

Signature of Individual Conducting Interview