l EARNit!, LLC. Participant Application Packet Checklist

Please fully complete the forms and steps below and submit the documents in person or by FAX or Email to FAX: (330) 956-5678 Email: kwambackrn2015@gmail.com.

If submitting via email, DO NOT enter your Social Security number on any form.

- A physical form, filled out completely by your health provider
- TB form completed by your health care provider
- Completed application
- Completed drug screen consent form
- Completed drug screen authorization form
- Completed HIPAA form

Thank you.

B/P_____
TEMP._____
PULSE_____
RESP. _____

PATIENT:
PHYSICIAN:
DATE:
DATE OF BIRTH:

Physical Assessment Form

Visit Day: _____ Height_____ Weight _____

PHYSICAL EXAMINATION: Must be performed by a MD, PA or designee

Body System	Not Done	Normal	Abnormal	If abnormal, specify below. Specify dates if known.	If abnormal, check if clinically significant
General	☐	☐	☐		☐ No ☐ Yes
Respiratory	☐	☐	☐		☐ No ☐ Yes
Skin / Breast	☐	☐	☐		☐ No ☐ Yes
Lymphatic / Hematologic	☐	☐	☐		☐ No ☐ Yes
Heart / Circulation	☐	☐	☐		☐ No ☐ Yes
Neurologic	☐	☐	☐		☐ No ☐ Yes
Other (Specify)	☐	☐	☐		☐ No ☐ Yes
Other (Specify)	☐	☐	☐		☐ No ☐ Yes

Comments:

_____ SIGNATURE DATE_____

Initial Tuberculin (TB) Skin Test Report Form

Student Information (please print)

Last Name _____ First Name _____

Clinic Information

Clinic Name _____ City, State _____ Phone _____

Please note: *If the student has recently traveled to a TB high-burden area as defined by the Centers for Disease Control (http://www.stoptb.org/countries/tbdata.asp), he/she must complete a TB Symptom Screening Form. The tuberculin skin test and this form must then be completed 8-10 weeks after returning to the U.S.*

☐ Tuberculin Skin Test

Date Given: Signature/Title: _

Date Read: Signature/Title: _

Step 1 Results: mm Interpretation: ☐ Negative ☐ Positive

** Results must be read within 48-72 hours by trained personnel.*

☐ Previous or current positive tuberculin skin test or received BCG

Students who have a positive TB skin test will need to provide proof of a negative chest x-ray (CXR) and then will need to repeat the CXR only if they experience symptoms of tuberculosis.

Chest x-ray date: **Results: ☐ Negative ☐ Positive**

Medical Treatment Plan: _

Student ☐ **can** ☐ **cannot** participate in providing patient care in all clinical areas.

Provider Signature/Title: _

ADMISSION APPLICATION FORM

l EARNit! LLC.

2223 Fulton Road, Suite 101, Canton Ohio 44709
Telephone (330) 515-0163 FAX (330) 956-5678

l EARNit! admits students and makes available to them its advantages, privileges and courses of study without regard to race, color, sex, religion, national origin, sexual orientation or disability.

This application form must be completed and submitted to the l EARNit! Training Center by the date specified in the l EARNit! email sent to you. In addition to this application form, the applicant is required to submit a Negative Mantoux (TB) test or chest X-Ray result and completed physical form.

DO NOT SEND SOCIAL SECURITY NUMBER BY EMAIL (leave blank) – It can be provided via phone call after submittal of this form.

If you do not have access to email or a printer, the forms are available at the Training Center.

APPLICANT SECTION

Applicant Name: Last: _____ First: _____ Middle: _____

Home Address: Street and Number: _____

City/Town: _____ State: _____ Zip Code: _____

Home Phone #: _____ Social Security #: _____ DOB: _____

Required Information

Submittal of a negative Mantoux (TB) test or chest X-Ray result and completed physical form (provided in the application email) is required prior to start of class. A valid test within the last year is acceptable.

I will submit the required information by the due date. Yes ☐ No ☐ If no, please explain.

_____

_____

_____

_____

_____

VOLUNTARY INFORMATION SECTION

The information requested in this section is not required for admission. Submission of the information is entirely voluntary. Information submitted voluntarily by the applicant will not affect the applicant's admission to the school. The information, if supplied, will be used for monitoring equal educational opportunity. In addition, note that applicants with disabilities may voluntarily self-identify for the purpose of requesting reasonable accommodations during the entire application and admission process.

Gender: □ Female □ Male

Race: □ American Indian or Alaskan Native □ Asian or Pacific Islander □ Black □ White □ Hispanic

□ Combination of two or more races

Person with a disability: □ Yes If yes, do you need accommodations during the application for admission process? □ Yes If yes, please describe the accommodations needed.

SIGNATURE SECTION

The statements and information furnished by the undersigned in this application form are true and complete.

The undersigned applicant gives permission for representatives of l EARNit! LLC. To release the applicant's records including grades, attendance, conduct/discipline records, as well as any other pertinent information that may be required by the State of Ohio and/or clinical site(s).

Drug screening will be performed during the interview process, which will be scheduled with the applicant after submittal of this application.

I understand that a non-refundable* security deposit of $100.00 is required with application and full payment of course fee balance is required prior to start date of course.

***If application is denied due to a background check (if requested by clinical site) or drug test, the security deposit less a $75.00 administrative fee will be refunded.**

My signature certifies that I have read and agree with the above statements.

Signature of Applicant _____ **Date:** _____

Applicant must be at least 18 years of age

CONSENT FOR PRE-EMPLOYMENT, RANDOM, OR REASONABLE SUSPICION DRUG TEST SCREEN AND RELEASE COVENANT NOT TO SUE AND INDEMNITY AGREEMENT

I hereby CONSENT to allow l EARNit!, LLC to take a specimen of my urine and submit it for a pre-employment, random, or reasonable suspicion drug test screen. I FURTHER CONSENT to allow the laboratory testing service to make the results of such screen available to the prospective or clinical site, l EARNit!, LLC.

In consideration for such services being rendered on my behalf, I hereby RELEASE the laboratory testing service, its officers, agents, and employees, from any and all claims which I might otherwise have due to such results being made so available. I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against l EARNit!, LLC, the laboratory testing service, their respective officers, agents or employees in connection with the results of such screen being made so available, and I hereby agree to INDEMNIFY and SAVE HARMLESS l EARNit!, LLC, the laboratory testing service, their respective officers, agents, and employees from all damages, expenses, reasonable attorney's fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screen being made so available.

SIGNED this _____day of _____, 20___.

Drug Testing
Consent Form

Company Name: l EARNit!, LLC.

Applicant/Employee Name: _____

I hereby agree to submit to a drug test by furnishing a sample of my urine analysis. I have been fully informed of the reason for this test and I understand what I am being tested for and the procedure involved. I am fully aware that the results of this test will determine my eligibility to participate in the l EARNit! LLC Nursing Assistant Program and the results will also be shared with any clinical site as necessary.

I understand that if at any time I refuse to submit to a drug or alcohol test, or if I otherwise fail to cooperate with the testing procedures, my application for this training program may be immediately withdrawn from consideration or I may be subject to immediate dismissal from the training program.

_____ _____

Signature of Applicant/Employee Date

_____ _____

Company Representative Date

Ohio HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date