Virginia Health Services
"In the care of people you know."

APPLICATION FOR ADMISSION
Nurse Aide Educational Program

Applicants are selected regardless of race, sex, age, disability, color, religion or national origin. No question on this application is asked for the purpose of excluding a qualified applicant on the basis of these factors.

How did you hear about this program? _____

_____

_____

APPLICANT'S PERSONAL DATA

FULL NAME (Last, First, Middle, Other (legal))		SOCIAL SECURITY NO.
PRESENT ADDRESS CITY, STATE, ZIP CODE		HOME PHONE: (____)_____ OTHER PHONE: (____)_____
IF YOU PREVIOUSLY APPLIED FOR VHS SCHOOL/PROGRAM, GIVE TITLE & DATES:		
HAVE YOU EVER BEEN EMPLOYED WITH VHS? ☐ YES ☐ NO	If Yes: Facility: _____ Supervisor: _____	Dept: _____ When: _____
PERSON TO NOTIFY IN CASE OF EMERGENCY	ADDRESS (Street, City, State)	TELEPHONE ( )
EMPLOYMENT LOCATION OF CONTACT PERSON	ADDRESS (Street, City, State)	TELEPHONE ( )

EDUCATION

SCHOOL	NAME & ADDRESS OF SCHOOLS ATTENDED	CHECK LAST YEAR COMPLETED				DID YOU GRADUATE?	DEGREE OR DIPLOMA
HIGH		1	2	3	4		
COLLEGE		1	2	3	4		
GRADUATE STUDY		1	2	3	4		
OTHER (Specify)		1	2	3	4		

WORK EXPERIENCE

FROM MO/YR	TO MO/YR	START WITH PRESENT OR MOST RECENT POSITION. LIST EMPLOYER'S NAME, FULL ADDRESS AND TELEPHONE NUMBER. ALL EXPERIENCE MUST BE ACCOUNTED FOR TO INCLUDE PERMANENT, TEMPORARY, MILITARY OR VOLUNTEER WORK.	POSITION HELD AND SUPERVISOR'S NAME	REASON FOR LEAVING

If more space is required please attach a summary of other experience.

Please continue on Page 2

IF YOU ARE NOT A U.S. CITIZEN, IDENTIFY YOUR LEGAL AUTHORIZATION TO WORK/STUDY IN THE U.S.:

HEALTH CARE PROVIDERS ONLY–HAVE YOU EVER BEEN DISCIPLINED IN ANY MANNER BY A STATE REGULATORY AGENCY FOR ANY REASON?
☐ NO ☐ YES If Yes, please explain:

PROGRAM ELIGIBILITY: ARE YOU PRESENTLY OR HAVE YOU PREVIOUSLY BEEN, AS A PROVIDER, EXCLUDED, DEBARRED, SUSPENDED, SANCTIONED OR OTHERWISE FOUND INELIGIBLE TO PARTICIPATE IN THE MEDICARE OR MEDICAID PROGRAMS OR FEDERAL PROCUREMENT PROGRAMS?
☐ NO ☐ YES If Yes, please provide additional details on an attached sheet.

REFERENCES

Give the names of four persons, not relatives, who know you and can give information about your suitability for this program.
For example, you may include a recent teacher, counselor, employer and/or clergyman.

NAME	POSITION/TITLE	COMPANY	PHONE

PERSONAL INFORMATION

Why do you want to be a Nurse Aide?

_____

_____

_____

_____

PLEASE READ CAREFULLY

EACH PARAGRAPH MUST BE READ AND INITIALED BEFORE THE APPLICATION IS SIGNED:

I consent to the release to Virginia Health Services from current and former employers, schools, law enforcement agencies, and other individuals and organizations, information relevant to my consideration for enrollment. Such parties may rely upon this authorization as a waiver of any claim whatsoever I may have as a result of the party responding candidly to an inquiry from Virginia Health Services. In providing this release, I acknowledge that unfavorable references may be evaluated in my admission to, and may result in, non-acceptance to the program.

Initial _____

I understand that a false statement or omission of facts and circumstances on this application and/or on other documents related to my qualifications and background may be grounds for not enrolling or for dismissing me from the program after I begin classes. I certify that to the best of my knowledge and belief, all statements are correct, complete, current, and made in good faith and that I will attach information necessary to meet this disclosure requirement.

Initial _____

If enrolled, I understand that I will be subject to and agree to abide by Virginia Health Services policies, procedures, rules, and practices. I also understand that I may be required to agree and submit to alcohol and/or substance abuse tests prior to my acceptance by Virginia Health Services and to periodic testing thereafter at the discretion of Virginia Health Services, in accordance with applicable Virginia Health Services policies and/or practices.

Initial _____

I understand that I may be accepted into a program even though certain background checks and investigations, and checking of references may not have been completed. If such inquiries, upon completion, establish information which in Virginia Health Services's opinion makes me unqualified, I understand I will be dismissed promptly.

Initial _____

I agree that Virginia Health Services may, without further consent, make lawful use of any photographic picture or video image it may make or cause to be taken of me.

Initial _____

SIGNATURE:_____ DATE:_____