HAWAII HEALTHCARE SCHOOL
Balance

ENROLLMENT FORM

STUDENT: _____ _____ _____ **GENDER: M F**
LAST NAME FIRST NAME MIDDLE INITIAL(S) CIRCLE ONE

HOME ADDRESS: _____ _____ _____ _____ _____
NUMBER & STREET NAME APT NUMBER (IF APPLICABLE) CITY STATE ZIP CODE

EMAIL ADDRESS: _____ **DATE OF BIRTH:** _____/_____/_____
MM DD YYYY

PHONE: _____ _____ **MARITAL STATUS: S M D W**
AREA CODE HOME PHONE AREA CODE CELL PHONE CIRCLE ONE: SINGLE (S) / MARRIED (M) / DIVORCED (D) / WIDOWED (W)

HIGHEST LEVEL OF EDUCATION COMPLETED: _____
EXAMPLE(S): DIPLOMA / CERTIFICATION / DEGREE / LICENSE

NAME OF LAST SCHOOL ATTENDED: _____
SCHOOL NAME

COMPLETION DATE: _____/_____ _____ _____ _____ _____
MM YYYY CITY STATE ZIP CODE COUNTRY

NAME: _____ **PHONE:** _____
FULL NAME (FIRST AND LAST NAME) AREA CODE MAIN PHONE

RELATIONSHIP TO STUDENT: _____ **PHONE:** _____
EXAMPLE(S): SPOUSE / PARENT / OTHER – EXPLAIN RELATIONSHIP AREA CODE ALTERNATE PHONE

COURSE NAME: _____

COURSE PERIOD: _____/_____/_____ TO _____/_____/_____ ***TUITION: $**_____

**Additional fees may apply depending on the requirements outlined based on your course selection. The total cost must be settled 3 business days prior to the first day of class.*

HOW DID YOU HEAR ABOUT OUR SCHOOL? _____
EXAMPLE(S): FAMILY / FRIEND / FORMER STUDENT / SOCIAL MEDIA / OTHER – EXPLAIN FURTHER

WHAT MOTIVATES YOUR INTEREST IN ENROLLING IN ONE OF OUR COURSES? _____

_____

DO YOU REQUIRE ANY ACCOMMODATIONS OR HAVE ANY SPECIAL NEEDS? Y N
CIRCLE ONE: YES (Y) / NO (N)

_____
IF YES, PLEASE SPECIFY IN DETAIL

I certify that my answers are true and complete the best of my knowledge. I understand that false or misleading information in my application will be grounds to deny or withdraw my admission or dismiss me after enrollment. Any changes in the agreement will not be binding on either the student or the school unless such changes are acknowledged in writing by an authorized representative of the school and by the student. We reserve the right to cancel classes for any reason or postpone classes due to insufficient enrollment. Every effort will be made to notify you of a cancelled class well in advance. If we cancel a class, you will receive a full refund of the class fee. In the event you decide to withdraw, a refund may be given if a written or in-person cancellation request is received at least 3 business days prior to the start of class. Please note that a telephone cancellation request is prohibited and is not deemed as an acceptable form of a cancellation request. No refunds will be granted thereafter. There is a $60.00 cancellation fee to cover administrative costs and for the return of textbooks and course materials. **A deposit of $300.00 must be paid at the time of registration.** Full payment must be paid 3 business days prior to the first day of class. I declare that I am 18 years or older, a high school graduate, and no criminal record affirming that I have no history of convictions for any felony offenses, including theft, abuse, assault, neglect, or drug use.

_____ _____/_____/_____
SIGNATURE TODAY'S DATE

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NURSE AIDE PROGRAM REQUIREMENTS

- ☐ Completed Physical Examination Form
- ☐ COVID-19 Vaccination Card
- ☐ 2-Step PPD (two negative TB skin tests) OR one blood test
    - If TB test is positive, a chest x-ray is required
    - Chest x-ray results must be dated with 5 years
- ☐ 2 MMR shots or Titers for MMR
- ☐ 2 Varicella shots or Titers
- ☐ 3 Hepatitis B shots or Titers
- ☐ Tdap (must be dated within 10 years)
- ☐ Influenza Vaccine
- ☐ Deposit of $300.00 must be paid at time of registration
- ☐ Uniform Size – circle one size ONLY: X-Small Small Medium Large X-Large XX-Large
- ☐ Remaining Balance paid by 3 business days prior to the start of the first day of class.

Student Name: _____

Program Requirements Submission Date: _____

Program requirements must be completed and submitted to our Administration Office by no later than 3 business days prior to the start of the first day of class.

FOR OFFICE USE ONLY:

DEPOSIT:

Payment Method: _____ Amount Received: $_____ Date: _____ Received By: _____

REMAINING BALANCE:

Payment Method: _____ Amount Received: $_____ Date: _____ Received By: _____

ACKNOWLEDGEMENT THAT ALL COURSE REQUIREMENTS ARE COMPLETED:

Documents Received Date: _____ Acknowledgement of Student Enrollment By: _____

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PHYSICAL EXAMINATION FORM

The State of Hawai'i Department of Health (DOH) mandates specific health requirements for enrollment in post-secondary institutions, as outlined in Title 11 (Chapter 157 and 164.2) of the Hawai'i Administrative Rules. Enrollment cannot proceed until all health clearances are fulfilled and submitted to the Admissions and Records Office. These clearances must include the signature, stamp, or imprinted name of a licensed practitioner or facility. Practitioners eligible to sign include physicians, advanced practice registered nurses (APRNs), or physician assistants (PAs) licensed in the United States. Incomplete or unsigned forms may be rejected and must be fully completed and signed by a licensed medical practitioner in the United States.

TO BE COMPLETED BY STUDENT

NAME: _____ **GENDER: M F**
LAST NAME FIRST NAME MIDDLE INITIAL(S) CIRCLE ONE

ADDRESS: _____
NUMBER & STREET NAME APT NUMBER (IF APPLICABLE) CITY STATE ZIP CODE

DATE OF BIRTH: ____/____/____ **PHONE:** _____ _____
MM DD YYYY AREA CODE HOME PHONE AREA CODE CELL PHONE

1. Have you been exposed to any communicable diseases such as Chicken Pox, Shingles, Measles, Pertussis (Whooping Cough), Tuberculosis, Hepatitis A, B, C?

   YES **NO** If yes is circled, please provide Description and Date _____

   _____

2. Do you have history of back pains, back surgery, or leg pains that would prohibit you from lifting, turning, or performing the job description of a Nurse Aide?

   YES **NO** If yes is circled, please provide Description and Date _____

   _____

3. Are you pregnant? **YES** **NO** If yes is circled, LMP _____ EDC _____
4. Any history of substance abuse, alcoholism, or violent behavior?

   YES **NO** If yes is circled, please provide Description and Date _____

   _____

5. Any history of depression or mental illness?

   YES **NO** If yes is circled, please provide Description and Date _____

   _____

TO BE COMPLETED BY A PHYSICIAN (MD or DO), ADVANCED PRACTICE REGISTERED NURSE (APRN) or PHYSICIAN ASSISTANT (PA) LICENSED IN THE UNITED STATES

1. List of medications currently taking, dosage, and reason: _____

   _____

2. Restrictions / Pains / Disabilities: _____
3. Previous Surgeries and Dates: _____
4. Healthcare Provider's Summary: _____

   _____

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TUBERCULOSIS (TB) CLEARANCE

I have evaluated the individual named above using the process set out in the State of Hawai'i DOH TB Clearance Manual and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawai`i Administrative Rules.

TB Screening Date: _____/_____/_____ Negative TB Risk Assessment Negative Test for TB Infection
CIRCLE ONE TEST RESULT

Negative IGRA (QuantiFERON / T-SPOT) Blood Test Positive Test for TB Infection, and Negative Chest X-Ray

This TB clearance provides a reasonable assurance that the individual was free from tuberculosis disease at the time of the exam. This does not imply any guarantee or protection from future tuberculosis risk.

Signature of Practitioner: _____ Date: _____

Print Name of Practitioner: _____ Licensure: _____

Facility Name: _____

Address: _____
STREET NUMBER AND STREET NAME SUITE NUMBER (IF APPLICABLE) CITY STATE ZIP CODE

PHONE: _____ _____ **EMAIL:** _____
AREA CODE OFFICE NUMBER AREA CODE FAX NUMBER

IMMUNIZATION

Immunizations shall include the complete date the vaccine was administered. All immunizations must meet the minimum ages and minimum intervals between doses. For a Religious exemption, see the Admissions and Records Office for the appropriate exemption form. For Medical Exemptions, see a U.S. licensed practitioner. Please refer to the Hawai'i Department of Health for guidelines on Immunization Requirements and Exceptions to these requirements.

1. **Tdap (Tetanus-diphtheria-acellular pertussis) 1 dose:** **Date:** _____
   Note: Valid Tdap dose must be administered on or after 10 years of age. Do not confuse it with DTaP (administered to children 0-6 years of age). Tdap was licensed for use in the U.S. in 2005. Doses recorded as "Tdap" with an administration date in the U.S. prior to 2005 should not be counted.

2. **MMR (Measles, Mumps, Rubella) 2 doses:** **Dose 1 Date:** _____ **Dose 2 Date:** _____
   Note: Mumps titers are no longer accepted for proof of immunity
   Exceptions: Born before 1957 Practitioner Initials: _____

3. **Varicella (chickenpox) 2 doses:** **Dose 1 Date:** _____ **Dose 2 Date:** _____
   Note: Titers are not accepted for proof of immunity.
   Exceptions: History of Varicella disease or Herpes Zoster Date: _____ Practitioner Initials: _____

   Born in the U.S. before 1980 Practitioner Initials: _____

Signature of Practitioner: _____ Date: _____

Print Name of Practitioner: _____ Licensure: _____

Facility Name: _____

Address: _____
STREET NUMBER AND STREET NAME SUITE NUMBER (IF APPLICABLE) CITY STATE ZIP CODE

PHONE: _____ _____ **EMAIL:** _____
AREA CODE OFFICE NUMBER AREA CODE FAX NUMBER

FOR OFFICE USE ONLY:

Notes: _____

Received By: _____ Date: _____