NOTE: All forms contained herein may be submitted at the Mandatory Orientation, but no later than the first day of class. The student will be dismissed from class for each day the forms are not completed and submitted. This will cause the student to be penalized absences which have the potential for dismissal from the CNA program.
Dear Applicant:

The following requirements must be completed for candidates who wish to be considered for the Certified Nursing Assistant Program (PRN 0090). It is the student’s responsibility to ensure the admission requirements are met.

- Complete the Daytona State College admission process
- Applicants will need the following TABE entrance scores:
  10th grade level in Reading and Language; 9th grade level in Math
Applicants who started high school in the 9th grade in 2003 or after at a Florida Public high school AND graduated from a Florida Public High School are not required to take the placement test. If you have any questions about your exemption status, please contact an academic advisor.
- Attend Mandatory CNA Orientation Wednesday, August 20, 2014, at the Daytona Campus, Health Sciences Hall, Building 320, Room 328 at 3:00 p.m.
- A Skills Lab Kit must be purchased from Coursey Enterprises, Inc.

Health/Medical Record
As a student in a health-related education program, prior to the first day of class, you are required to have:
A completed physical examination, verification of a negative tuberculin skin test, current BLS Card-Health Care Provider, verification of immunizations and immunity (refer to the physical form enclosed), and a Level II Background Check and Drug Screening. Immunization (Flu) Vaccine is mandatory for students entering during the fall and spring semesters. Please attach a copy of your immunization record to the health history form. If you do not have this record you may contact your physician, clinic, or public health dept. to obtain the immunizations or a titer verifying immunity. The Hepatitis B vaccine is not required, but encouraged. The vaccine may be obtained from your physician or the Volusia County Health Department for approximately $150. You are required to indicate on the Hepatitis B vaccination record your intentions to take or decline the vaccine.
2) Verification of immunity can be completed by a titer which consists of blood drawn in a laboratory setting. If the results are negative or equivocal the student must obtain the immunization. If the health history and immunization is not complete the student will not be allowed to complete the program.

Criminal Background Checks and Drug Screening
Your admission to the Certified Nursing Assistant program is contingent upon the satisfactory completion of both a drug screening and a background check consisting of a fingerprint check of state and federal criminal history information conducted through the Florida Department of Law Enforcement (FDLE) and Federal Bureau of Investigation (FBI), at an approximate cost of $90. Enclosed are instructions for obtaining a background check. For acceptance and continuing enrollment in a health related program the student must not have been found guilty, regardless of adjudication, of any offense that would disqualify the student from employment in a health care or a community health setting. When submitted, these records will become the property of the College, and will not be
available for copying or for use to meet the requirements of outside employers. Students who are out of the program for six months or more must submit new records.

All appropriate forms are included in this information packet:
- Hepatitis B Vaccination Record
- Acknowledgement and Consent for Release of Information
- Physical Examination Form with TB test
- Coursey Skills Lab Kit order form
- Background Check and Drug Screening Student Instructions (**must be completed prior to start of classes**).
- VECHS Waiver Agreement (**must be turned in to nursing department after registration in CNA program**).

The following forms may be turned in on orientation day, but no later than the first day of class:
- Basic Life Support (BLS) Healthcare Provider Card – Adult, Infant, Child and AED (Automatic External Defibrillator) -- **ONLY AMERICAN HEART ASSOCIATION AFFILIATED OR AMERICAN RED CROSS ACCEPTED** (see samples pages 4 & 5).
- Completed Physical Examination Form
- Verification of immunizations against tetanus, measles, mumps and rubella
- Completed Hepatitis B Vaccine form showing dates of vaccination or declination
- Written physician verification of a **negative** tuberculosis test or chest X-Ray
- VECHS Waiver

On the first day of class you are required to bring the following:
- Textbooks, notebook paper, #2 pencil, black-ink pen
- Lab kit
- Uniforms must be worn to class, laboratory and clinical

**Paperwork must be turned in prior to entering the clinical setting. It would benefit the student to have all paperwork completed and given to the instructor by the first day of class.**

Sincerely,

[Signature]

Dr. Linda Miles
Chair, School of Nursing
Admission Requirements:

1. Complete an Admission Application to the College (either online or at the Admissions Office on any campus).

2. A Level II Criminal Background Check and Drug Screening including drug screening and fingerprinting MUST be completed BEFORE THE FIRST DAY OF CLASS as well as a CPR-Health Care Provider Class, TB Test and Physical. The classes for CPR MUST be offered through the American Heart Association or American Red Cross. The American Red Cross card will state Professional Rescuer and the American Heart Association will state Health Care Provider. All others will NOT be accepted.

3. A MANDATORY ORIENTATION is required before beginning the CNA program.

4. All paperwork including: Physical Form, Negative TB, Immunization Record, Hepatitis B Form, and an active CPR card must be turned in the first day of class.

CPR TRAINING: This training may be obtained through:

⇒ American Red Cross (ARC) - (386) 226-1400
⇒ American Heart Association (AHA) - (800) 242-8721
American Heart Association affiliate:
⇒ Daytona State College Community Training - (386) 506-3298 or 4490
⇒ Daytona State College Emergency Medical Services - (386) 506-3816

The only recognized certificates/cards are affiliated with the American Heart Association and/or American Red Cross.
UNIFORM REQUIREMENTS

CEIL BLUE UNIFORM: AUTHENTIC CHEROKEE WORKWEAR  
V-NECK TUNIC #4700; UTILITY PANT #4200 (women) #4000 (men)

Male Apparel and Accessories
- Men’s ceil blue uniform top & pants (SEE ABOVE)
- Daytona State College nursing patch (purchase at college bookstore); attach to left sleeve of uniform
- White socks
- White uniform shoes (no color or trim)
- Watch with sweep-seconds hand
- Allowed to wear one flat ring only; one pair of earrings; NO other jewelry.
- Visible tattoos must be covered
- Hair groomed and, if long, pulled back
- Facial hair has to be well groomed
- No bracelets allowed
- Nails groomed and clean
- Name tag: 1”x3” royal blue background with white lettering

Example:
John Doe
Daytona State College
CNA Student

Female Apparel and Accessories
- Women’s ceil blue uniform top & pants (SEE ABOVE)
- Daytona State College nursing patch (purchase at college bookstore); attach to left sleeve of uniform
- White socks
- White uniform shoes (no color or trim)
- Watch with sweep-seconds hand
- Allowed to wear one flat ring only and one pair of earrings; NO other jewelry.
- Visible tattoos must be covered
- Hair groomed and, if long, pulled back
- No bracelets allowed
- Nails groomed and clean (**artificial nails not allowed**)  
- Name tag: 1”x3” royal blue background with white lettering

Example:
Jane Doe
Daytona State College
CNA Student

UNIFORMS MUST BE WORN ON THE FIRST CLASS DAY
# Healthcare Personnel Vaccination Recommendations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendations in brief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Give 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2). Give IM. Obtain anti-HBs serologic testing 1–2 months after dose #3.</td>
</tr>
<tr>
<td>Influenza</td>
<td>Give 1 dose of influenza vaccine annually. Give inactivated injectable vaccine intramuscularly or live attenuated influenza vaccine (LAIV) intranasally.</td>
</tr>
<tr>
<td>MMR</td>
<td>For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below. Give SC.</td>
</tr>
<tr>
<td>Varicella (chickenpox)</td>
<td>For HCP who have no serologic proof of immunity, prior vaccination, or history of varicella disease, give 2 doses of varicella vaccine, 4 weeks apart. Give SC.</td>
</tr>
<tr>
<td>Tetanus, diphtheria, pertussis</td>
<td>Give a dose of Tdap as soon as feasible to all HCP who have not received Tdap previously and to pregnant HCP with each pregnancy (see below). Give Td boosters every 10 years thereafter. Give IM.</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Give 1 dose to microbiologists who are routinely exposed to isolates of <em>N. meningitidis</em> and boost every 5 years if risk continues. Give MCV4 IM; if necessary to use MPSV4, give SC.</td>
</tr>
</tbody>
</table>

*Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material.*

### Hepatitis B

Healthcare personnel (HCP) who perform tasks that may involve exposure to blood or body fluids should receive a 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Test for hepatitis B surface antibody (anti-HBs) to document immunity 1–2 months after dose #3.

- If anti-HBs is at least 10 mIU/mL (positive), the patient is immune. No further serologic testing or vaccination is recommended.
- If anti-HBs is less than 10 mIU/mL (negative), the patient is unprotected from hepatitis B virus (HBV) infection; revaccinate with a 3-dose series. Retest anti-HBs 1–2 months after dose #3.
  - If anti-HBs is positive, the patient is immune. No further testing or vaccination is recommended.
  - If anti-HBs is negative after 6 doses of vaccine, patient is a non-responder.

For non-responders: HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood. It is also possible that non-responders are people who are HBsAg positive.

**Note:** Anti-HBs testing is not recommended routinely for previously vaccinated HCP who were not tested 1–2 months after their original vaccine series. These HCP should be tested for anti-HBs when they have an exposure to blood or body fluids. If found to be anti-HBs negative, the HCP should be treated as if susceptible.

### Influenza

All HCP, including physicians, nurses, paramedics, emergency medical technicians, employees of nursing homes and chronic care facilities, students in these professions, and volunteers, should receive annual vaccination against influenza. Live attenuated influenza vaccine (LAIV) may be given only to non-pregnant healthy HCP age 49 years and younger. Inactivated injectable influenza vaccine (IIV) is preferred over LAIV for HCP who are in close contact with severely immunosuppressed people (e.g., stem cell transplant patients) when patients require protective isolation.

### Measles, Mumps, Rubella (MMR)

HCP who work in medical facilities should be immune to measles, mumps, and rubella.

- HCP born in 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) laboratory confirmation of disease or immunity or (b) appropriate vaccination against measles, mumps, and rubella (i.e., 2 doses of live measles and mumps vaccines given on or after the first birthday and separated by 28 days or more, and at least 1 dose of live rubella vaccine). HCP with 2 documented doses of MMR are not recommended to be serologically tested for immunity; but if they are tested and results are negative or equivocal for measles, mumps, and/or rubella, these HCP should be considered to have presumptive evidence of immunity to measles, mumps, and/or rubella and are not in need of additional MMR doses.

- Although birth before 1957 generally is considered acceptable evidence of measles, mumps, and rubella immunity, healthcare facilities should consider recommending 2 doses of MMR vaccine routinely to unvaccinated HCP born before 1957 who do not have laboratory evidence of disease or immunity to measles and/or mumps, and should consider 1 dose of MMR for HCP with no laboratory evidence of disease or immunity to rubella. For these same HCP who do not have evidence of immunity, healthcare facilities should recommend 2 doses of MMR vaccine during an outbreak of measles or mumps and 1 dose during an outbreak of rubella.

### Varicella

It is recommended that all HCP be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart, history of varicella or herpes zoster based on physician diagnosis, laboratory evidence of immunity, or laboratory confirmation of disease.

### Tetanus/Diphtheria/Pertussis (Td/Tdap)

All HCP who have not or are unsure if they have previously received a dose of Tdap should receive a dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Pregnant HCP need to get repeat doses during each pregnancy. All HCP should then receive Td boosters every 10 years thereafter.

### Meningococcal

Vaccination with MCV4 is recommended for microbiologists who are routinely exposed to isolates of *N. meningitidis*. Use MPSV4 only if there is a permanent contraindication or precaution to MCV4.

---

**References**


For additional specific ACIP recommendations, refer to the official ACIP statements published in *MMWR*. To obtain copies, visit CDC’s website at www.cdc.gov/vaccines/pubs/acip-list.htm; or visit the Immunization Action Coalition (IAC) website at www.immunize.org/acip.
STUDENT: ___________________________________________________________________
SS #: _____________________________ PROGRAM: ______________________________

HEPATITIS B VACCINATION RECORD

A copy of the medical report must be attached to this form for each date entered below. The student
should retain the original copy of this medical report for future use.

Date of First Injection: ________________Physician’s Signature _____________________________

Date of Second Injection: _____________Physician’s Signature______________________________
(30 days after first injection)

Date of Third Injection: _______________Physician’s Signature______________________________
(Six months after first injection)

Date of Titer Level: __________________Physician’s Signature______________________________
(Two months after last injection)

DECLINATION (Declining) FORM

I understand that due to my clinical exposure to blood or other potentially infectious materials I may be
at risk of acquiring Hepatitis B Virus (HBV) infection. I have been advised that I can be vaccinated with
Hepatitis B vaccine, at my own expense. However, I decline the Hepatitis B vaccination at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious
disease.

Student’s Signature: ____________________________________________ Date: __________

Program Manager’s Signature: ____________________________________________ Date: __________
ACKNOWLEDGEMENT AND CONSENT FOR RELEASE OF INFORMATION

This is to acknowledge that I have received a copy of the Student Nursing Handbook and I have read and understand the contents thereof. I hereby agree to abide by its regulations.

I understand that this form must be submitted to the classroom instructor during the first week of class.

I agree to have my personal, educational, health and background records released to professional organizations/health care agencies requesting that information.

I understand that the nursing department may be required to copy my personal information for professional organizations/health care agencies such as driver’s license, social security card or additional documents to receive clearance for clinical placement.

I agree to have my social security number released, to the Florida Board of Nursing for application for licensure, as well as professional organizations/health care agencies.

I agree to have information regarding my attendance and performance released for financial aid purposes.

I understand that I may not participate in any nursing program until I have all my records on file in the nursing department (health, CPR, drug screen and background checks) and that these records must be kept updated, or I could be withdrawn from the program.

I understand that orientation to clinical facilities is mandatory. Absence for any reason will result in withdrawal from the course.

I understand that information that has been disclosed to me from the patient’s privacy is protected by state and federal law. State law prohibits me from making any disclosure of medical information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by federal, state or local law.

Changes may be made to departmental, division or college guidelines at any time. Should a change occur, students will be notified verbally and in writing as to what the change entails and the date it will take effect. Students will be given a copy of the change to keep for their records, and one to sign which will be included in their file.

_________________________________  ____________________________
SIGNATURE                        PRINT NAME

_________________________________
DATE
Daytona State College
School of Nursing Physical Examination Form

Student Name__________________________________ Month/Year admitted to program________

Please print

1. TO BE COMPLETED BY PHYSICIAN/ARNP/PA (Please comment on condition)

EYES: __________________________________________

EARS: __________________________________________

NOSE: __________________________________________

MOUTH: __________________________________________

THROAT: __________________________________________

TEETH: __________________________________________

HEART: __________________________________________

LUNGS: __________________________________________

VARICOSE VEINS: __________________________________

BLOOD PRESSURE________________________

2. IMMUNIZATIONS: (To be current) ATTENTION HEALTHCARE PROVIDERS.

NOTE: Personal history/RECORD of MMR is NOT acceptable. PROOF OF IMMUNITY IS REQUIRED (VIA TITER).

TETANUS: (Date)__________________________________

(Recommend not to exceed 10 years since last booster)

Follow CDC criteria if unavailable.

TUBERCULOSIS (MANTOUX OR PPD)

Date ____________________________ Results ____________

(if POSITIVE, Chest Radiology Report must be attached)

MMR: Date 1st injection ________________

or titer results ________________

Date 2nd injection ________________

If born 1957 or later without serologic evidence of immunity, two doses of vaccine four weeks apart are required. A booster may be considered without diagnosis of measles and mumps or laboratory evidence of immunity. A physician or healthcare staff is to interpret lab results. Students attach a copy of lab proof to form.

3. VARICELLA (Chickenpox)

NOTE: Personal history of Varicella is NOT acceptable. Proof of immunity is required (via titer or booster shot).

VARICELLA: Date 1st injection ________________

or titer results ________________

Date 2nd injection ________________

Date ________________

Two doses of vaccine given at least 28 days apart or history of varicella or herpes zoster based on physician diagnoses, laboratory evidence of immunity or laboratory confirmation of the disease. A physician or healthcare staff is to interpret lab results.

4. INFLUENZA: Date ____________________________ One dose of influenza vaccine annually.

5. This applicant is in ____________________________ physical and mental health and is / is not qualified to enter the Nursing Programs at Daytona State College.

6. Comment on any specific health problems which might interfere with the professional activities within the Nursing Programs such as: back or neck injuries, allergies, physical handicaps, drug idiosyncrasies, etc.

____________________________________________________________________________________

____________________________________________________________________________________

7. PHYSICIAN/ARNP/PA (please print)______________________________________________________

Signature ________________________________ Date ____________________________

**Office Stamp Required**
8. TO BE COMPLETED BY STUDENT:

**PAST HEALTH HISTORY**

What childhood diseases have you had?
Include dates:

__________________________________

__________________________________

__________________________________

Have you had any of these conditions?
Specify dates (If none, so state)

Arthritis__________________________
Polioymyelitis_____________________
Tuberculosis_______________________
Asthma___________________________
Rheumatic fever____________________
Malignancies_______________________
Jaundice__________________________
Epilepsy__________________________
Diabetes__________________________
Back Injury_______________________

Any type of convulsions? Yes___ No_____
If yes, explain:

__________________________________

__________________________________

Any allergies to foods or medications?
Yes____ No_____
If yes, explain:

__________________________________

__________________________________

**PRESENT HEALTH STATUS**

Do you have frequent or severe headaches?
Yes____ No_____
If yes, explain:

__________________________________

__________________________________

Are you taking any medications (drugs, over-the-counter and/or herbals) for a health problem? List Medications
Yes____ No_____ 
If yes, explain:

__________________________________

__________________________________

Do you wear glasses/contacts? Yes____ No_____

Do you have a hearing impairment?
Yes____ No_____
If yes, explain:

__________________________________

__________________________________

If you have a physical disability, a physician’s Release stating “No Restrictions” is mandatory.

Are you covered by health insurance?
Yes____ No_____ 
Name of Company_____________________

Have you had frequent absences/lateness from school or work because of health problems?
Yes____ No_____ 
If yes, explain:

__________________________________

__________________________________

This form must be submitted to your nursing instructor the first day of class and may not be dated later than one year prior to your entry into the nursing program.
DAYTONA STATE COLLEGE
BASIC CNA / K2141
August 2014

NAME_________________________________________________________________

ADDRESS__________________________________________________________

CITY __________________________ STATE __________ ZIP CODE ____________

PHONE________________________ EMAIL________________________________

QTY DESCRIPTION AMOUNT

___ BASIC CNA $56.25

Please order by August 18th to insure delivery by August 26th
Do not send orders to the school of nursing. *Kits are shipped UPS Ground to your home. No PO Box’s.
Please allow 5-10 business days for delivery. Note: UPS Ground does not run on weekends.
(KITS ARE NON-REFUNDABLE)

WAYS TO PLACE YOUR ORDER:

1. ORDER ONLINE @ www.cestudents.com.
   ENTER YOUR USERNAME: dsc/cna-august AND PASSWORD: k2141
2. MAIL ORDER TO ADDRESS LISTED ABOVE
3. FAX ORDER TO (580) 286-7762

“NO” PHONE ORDERS WILL BE ACCEPTED.

METHOD OF PAYMENT:

__ MONEY ORDER (NO PERSONAL CHECKS)
__ VISA
__ MASTERCARD
*A charge from Coursey Enterprises will appear on your next credit card statement.

___ ___ ___ ___ / ___ ___ ___ ___ / ___ ___ ___ ___ / ___ ___ ___ ___

NAME (PRINT EXACTLY AS IT APPEARS ON CARD) ____________EXPIRATION DATE

(_____)____________________ PHONE NUMER
ADDRESS IF DIFFERENT FROM STUDENT __________________________________

________________________________ SIGNATURE
Drug Test and Fingerprint Instructions

The total price is $90 for both the fingerprints (which will provide us with your background check results) and the drug test. Go to: www.CertifiedBackground.com, then to “Place Order” & enter the package code: DA68

You will then proceed to the CertifiedProfile. CertifiedProfile is a secure platform that allows you to order your drug test & fingerprints online. Enter your personal information and continue to create your account. Follow the prompts and then enter in your payment information. Once completed, you will see the following screen:

Click on “Drug Test” then click on “Take Your Drug Test” and from here you click on “Download and Print”. NOTE: The form is available to you within 24 hours after you create your Certified Profile. Print and take to Drug Testing Facility.

Click on “Florida FDLE Fingerprints – Daon” then click on “File Download with Confirm Receipt” then click on “Download File”. This information will be used for Daon’s Website.

Click on “Access Daon’s Website” and then click on the web address link. This will take you to the fingerprinting website. Use the download file from above to enter in appropriate information. Create your account and enter in the necessary information.

PROGRAM – VECHS VOLUNTEER ORI – V64020008 REASON - VOLUNTEER

Please note: Payments are billed to CertifiedBackground.com. You do not pay anything directly to Daon including their facility.

Please print out your confirmation page and bring it with you to your fingerprinting appointment.

After you place your order through certified background, your drug test results will be posted directly to your CertifiedProfile account. You will be notified if there is any missing information needed in order to process your order. Your order will show as “In Process” until it has been completed in its entirety. Your fingerprint results are sent directly to the school from the Florida Department of Law Enforcement (FDLE).
Applicants for Daytona State College’s Certified Nursing Assistant Programs must be free of offenses that would disqualify one for employment in a health care or community health setting. This policy is the result of requirements by clinical agencies that must comply with state and federal regulations.

Each applicant must be screened through the Florida Department of Law Enforcement (FDLE) and the Abuse Registry and/or comparable checks from state(s) of prior residence.

Judgments of guilty or pleas of nolo contendere (no contest) to the following crimes will disqualify applicants from entering into the Certified Nursing Assistant Programs:

- Murder
- Manslaughter
- Vehicular homicide
- Killing of an unborn child by injury to the mother
- Assault, if the victim of the offense was a minor
- Aggravated assault
- Battery, if the victim of the offense was a minor
- Aggravated battery
- Kidnapping
- False imprisonment
- Sexual battery
- Prohibited acts of persons in familial or custody authority
- Prostitution
- Lewd and lascivious behavior
- Lewdness and indecent exposure
- Arson
- Theft, robbery, and related crimes if the offense is a felony
- Fraudulent sale of controlled substances, only if the offense was a felony
- Incest
- Abuse or neglect of a disabled adult or elderly person
- Exploitation of disabled adult or elderly person
- Aggravated child abuse
- Child abuse
- Negligent treatment of children
- Sexual performance by a child
- Obscene literature
- Drug offenses which were a felony, or if the offense involved a minor
IMPORTANT NOTICE: Pursuant to Section 456.0635, Florida Statutes, health care boards or the department shall refuse to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:
   1. For felonies of the first or second degree, more than 15 years before the date of application.
   2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).
   3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application;
(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application;
(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;
(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application; or
(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General’s List of Excluded Individuals and Entities.

For acceptance into the program the student must not have been found guilty, regardless of adjudication, of an offense that would disqualify the student under the same standard(s) set for employment as a CNA in a health care agency. Any student who has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to, any offense under the provisions of Florida Statutes 435.03 or under a similar statute of another jurisdiction will be required to request an Exemption from Disqualification from each clinical agency the student is assigned.

Exemptions from Disqualification can only be granted through the Department of Health, CNA Registry, 40502 Bald Cypress Way Bin C13, Tallahassee, FL 32399, (850) 245-4567.

While enrolled in Daytona State College Certified Nursing Assistant Programs, the student is responsible for notifying the chair/assistant chair of any arrests, regardless of adjudication, that occur after acceptance and during enrollment in the program. Failure to promptly notify the chair/assistant chair shall be grounds for dismissal from the program.
VECHS WAIVER AGREEMENT AND STATEMENT

Volunteer & Employee Criminal History System (VECHS)
for Criminal History Record Checks
under the National Child Protection Act of 1993, as amended,
and Section 943.0542, Florida Statutes

Pursuant to the National Child Protection Act of 1993, as amended, and section 943.0542, Florida Statutes, this form must be completed and signed by every current or prospective employee, volunteer, and contractor/vendor, for whom criminal history records are requested by a qualified entity under these laws.

I hereby authorize Daytona State College (DSC) to submit a set of my fingerprints and this form to the Florida Department of Law Enforcement for the purpose of accessing and reviewing Florida and national criminal history records that may pertain to me. I understand that I would be able to receive any national criminal history record that may pertain to me directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34, and that I could then freely disclose any such information to whomever I choose. By signing this Waiver Agreement, it is my intent to authorize the dissemination of any national criminal history record that may pertain to me to the Qualified Entity with which I am or am seeking to be employed or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes.

I understand that, until the criminal history background check is completed, you may choose to deny me unsupervised access to children, the elderly, or individuals with disabilities. I further understand that, upon request, you will provide me a copy of the criminal history background report, if any, you receive on me and that I am entitled to challenge the accuracy and completeness of any information contained in any such report. I may obtain a prompt determination as to the validity of my challenge before you make a final decision about my status as an employee, volunteer, contractor, or subcontractor.

A national criminal history background check on me has previously been requested by:

(Name and Address of Previous Qualified Entity) ___________________________ (Year of Request) ___________________________

I ___ have OR ___ have not been convicted of a crime.
If convicted, describe the crime(s) and the particulars of the conviction(s) in the space below:

____________________________________________________________________________________________________________________________________________________

I ___ do OR ___ do not authorize you to release my criminal history records, if any, to other qualified entities.

I am a current or prospective (check one): Employee [ ] Volunteer X Contract/Vendor [ ]

Signature: ______________________________________________________ Date: _____________________

Printed Name: ______________________________________________________

Address: ______________________________________________________________________________________

Date of Birth: ___________________________

TO BE COMPLETED BY QUALIFIED ENTITY:

Entity Name: Daytona State College
Address: 1200 West International Speedway Blvd., Daytona Beach, FL 32114
Telephone: (386) 506-3189 Fax: (386) 506-3300

FDLE Assigned Qualified Entity Number: V64020008