

Fall 2022 C.N.A Requirements for Clinical

1. Negative PPD (**given later than June 30, 2022**) or negative chest x-ray if you have a history of a positive PPD (**completed later than June 30, 2022**).
2. Positive rubella titer or proof of two doses of MMR or rubella vaccine.
3. Positive mumps titer or proof of two doses of MMR or mumps vaccine
4. Positive measles titer or proof of two doses of MMR or measles vaccine
5. Positive varicella titer or proof of two doses of varicella vaccine.
6. Positive hepatitis B titer or proof of three doses of hepatitis B vaccine.
7. Proof of tetanus/diphtheria (Td) within the last ten years.
8. Flu vaccination for current year (**August 2022– April 2023**)
9. Proof of completed Covid 19 vaccination plus Booster

10. Ten panel-drug plus alcohol screening (see attached drug testing list/info). It is mandatory that you obtain this screening from Castle Branch (information is located on the Gavilan website <http://www.gavilan.edu/academic/ah/CNA.php>) for a cost of \$39.00.
11. Live-Scan submission must be submitted on first day of class which will be **Tuesday, August 9, 2022 with receipt to instructor**. CDPH clearance will be required to receive certification as a Certified Nursing Assistant.

Note: You must complete all three (3) live scan forms included in this packet and take to your preferred livescan location. Follow the included livescan sample when completing the forms.

ALL HEALTH STATEMENTS, DRUG SCREENING, PPD TEST, & VACCINE INFORMATION MUST BE COMPLETED BY Tuesday, August 23, 2022 OR YOU WILL NOT BE ABLE TO ATTEND CLINICAL THEREFORE JEOPORDIZING YOU COMPLETING THE PROGRAM.

NOTE: CDPH regulations require that a Health and Physical and TB test be completed for all healthcare workers 90 days prior to starting clinical. All other requirements are policy and procedures enacted by hospitals/facilities in order for students to attend clinical.



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name Middle Initial Suffix

Other Name
(AKA or Alias) Last

First Suffix

Date of Birth Sex ☐ Male ☐ Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing
Number

(Agency Billing Number)

Place of Birth (State or Country) Social Security Number

Misc.
Number

(Other Identification Number)

Home
Address Street Address or P.O. Box

City State ZIP Code

Your Number: OCA Number (Agency Identifying Number)

Level of Service: ☐ DOJ ☐ FBI

(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI)

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name Middle Initial Suffix

Other Name
(AKA or Alias) Last

First Suffix

Date of Birth Sex ☐ Male ☐ Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing
Number

(Agency Billing Number)

Place of Birth (State or Country) Social Security Number

Misc.
Number

(Other Identification Number)

Home
Address Street Address or P.O. Box

City State ZIP Code

Your Number: OCA Number (Agency Identifying Number)

Level of Service: ☐ DOJ ☐ FBI

(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI)

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name Middle Initial Suffix

Other Name
(AKA or Alias) Last

First Suffix

Date of Birth Sex ☐ Male ☐ Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing
Number

(Agency Billing Number)

Place of Birth (State or Country) Social Security Number

Misc.
Number

(Other Identification Number)

Home
Address Street Address or P.O. Box

City State ZIP Code

Your Number: OCA Number (Agency Identifying Number)

Level of Service: ☐ DOJ ☐ FBI

(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI)

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Privacy Notice

As Required by Civil Code § 1798.17

Collection and Use of Personal Information. The California Justice Information Services (CJIS) Division in the Department of Justice (DOJ) collects the information requested on this form as authorized by Business and Professions Code sections 4600-4621, 7574-7574.16, 26050-26059, 11340-11346, and 22440-22449; Penal Code sections 11100-11112, and 11077.1; Health and Safety Code sections 1522, 1416.20-1416.50, 1569.10-1569.24, 1596.80-1596.879, 1725-1742, and 18050-18055; Family Code sections 8700-87200, 8800-8823, and 8900-8925; Financial Code sections 1300-1301, 22100-22112, 17200-17215, and 28122-28124; Education Code sections 44330-44355; Welfare and Institutions Code sections 9710-9719.5, 14043-14045, 4684-4689.8, and 16500-16523.1; and other various state statutes and regulations. The CJIS Division uses this information to process requests of authorized entities that want to obtain information as to the existence and content of a record of state or federal convictions to help determine suitability for employment, or volunteer work with children, elderly, or disabled; or for adoption or purposes of a license, certification, or permit. In addition, any personal information collected by state agencies is subject to the limitations in the Information Practices Act and state policy. The DOJ's general privacy policy is available at <http://oag.ca.gov/privacy-policy>.

Providing Personal Information. All the personal information requested in the form must be provided. Failure to provide all the necessary information will result in delays and/or the rejection of your request.

Access to Your Information. You may review the records maintained by the CJIS Division in the DOJ that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

Possible Disclosure of Personal Information. In order to process applications pertaining to Live Scan service to help determine the suitability of a person applying for a license, employment, or a volunteer position working with children, the elderly, or the disabled, we may need to share the information you give us with authorized applicant agencies.

The information you provide may also be disclosed in the following circumstances:

- With other persons or agencies where necessary to perform their legal duties, and their use of your information is compatible and complies with state law, such as for investigations or for licensing, certification, or regulatory purposes;
- To another government agency as required by state or federal law.

Contact Information. For questions about this notice or access to your records, you may contact the Associate Governmental Program Analyst at the DOJ's Keeper of Records at (916) 210-3310, by email at keeperofrecords@doj.ca.gov, or by mail at:

Department of Justice
Bureau of Criminal Information & Analysis
Keeper of Records
P.O. Box 903417
Sacramento, CA 94203-4170



**SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES
REQUEST FOR LIVE SCAN SERVICE**

Applicant Submission

A1226

ORI (Code assigned by DOJ)

Certification

Authorized Applicant Type

Certified Nurse Assistant (CNA) or Home Health Aide (HHA)

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

California Department of Public Health (CDPH)

Agency Authorized to Receive Criminal Record Information

MS 3301, P.O. Box 997416

Street Address or P.O. Box

Sacramento

CA

95899-7416

City

State

Zip Code

03314

Mail Code (five-digit code assigned by DOJ)

(Leave blank)

Contact Name (mandatory for all school submissions)

(Leave blank)

Contact Telephone Number

Applicant Information:

Your last name

Last Name

Other Name Other last names known as

(AKA or Alias) Last

(Check one)

Date of Birth

Sex: ☐ Male ☐ Female

Date of Birth

Height

Weight

Color

Color

Height

Weight

Eye Color

Hair Color

Place of Birth

*Social Security Number (Required by CDPH)

Place of Birth (State or Country)

Social Security Number

Home

Your mailing address

Address

Street Address or P.O. Box

Your first name & middle initial

First Name

Middle Initial

Suffix

Other first names known as

First Name

Suffix

California Driver's License Number

Driver's License Number

Billing

Not Applicable

Number

(Agency Billing Number)

Misc.

Your telephone number

Number

(Other Identification Number)

City

State

Zip Code

Your Number: ***Social Security Number (Required by CDPH)**

OCA Number (Agency Identification Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list ATI number:

(Must provide proof of Rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)

Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City

State

Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

Recommended option for drug & alcohol screening:



Order Instructions for **Gavilan College - Allied Health**

1. Go to <https://mycb.castlebranch.com/>
2. In the upper right hand corner, enter the Package Code that is below.

Package Code **GA95dt**: Drug Test **Cost: \$39.00**

About

About CastleBranch

Gavilan College - Allied Health and CastleBranch – one of the top ten background screening and compliance management companies in the nation – have partnered to make your onboarding process as easy as possible. Here, you will begin the process of establishing an account and starting your order. Along the way, you will find more detailed instructions on how to complete the specific information requested by your organization. Once the requirements have been fulfilled, the results will be submitted on your behalf.

Order Summary

Payment Information

Your payment options include Visa, Mastercard, Discover, Debit, electronic check and money orders. Note: Use of electronic check or money order will delay order processing until payment is received.

Accessing Your Account

To access your account, log in using the email address you provided and the password you created during order placement. Your administrator will have their own secure portal to view your compliance status and results.

Contact Us

For additional assistance, please contact the Service Desk at 888-723-4263 or visit <https://mycb.castlebranch.com/help> for further information.

HEALTH STATEMENT

TO BE COMPLETED BY STUDENT:

Name of Applicant: _____ Program: _____
Last Name First Name

Do you have any medical condition or disability which may limit your ability to perform the tasks and functions of a healthcare worker? ☐ Yes ☐ No

If yes, what can be done to accommodate your disability? _____

Students admitted to the program are required to complete immunizations or titers in accordance with agency policies and CDC recommendations for healthcare personnel. Written proof must be on file.

TO BE COMPLETED BY EXAMINING PHYSICIAN/NURSE PRACTITIONER:

Please review the attached requirements for healthcare students. Complete this form and **return to the student in a sealed envelope.**

Date of complete physical examination: _____

Does the applicant have any medical condition or disability which may limit his/her ability to perform the tasks and functions of a healthcare worker? ☐ Yes ☐ No

If yes, what can be done to accommodate his/her disability? _____

 Upon review of the physical exam and lab results, I certify that this student is medically able to perform all clinical activities without restrictions and that the student does not have a health condition that creates a hazard to self or others.

MD/NP Signature _____ Date _____

Print Name: _____ License #: _____

Address: _____

Phone number (____) _____

Physical Requirements for healthcare workers

The health and safety of the consumer of health care must be protected. The student must be able to perform the work required in the program without limitation. The student will refrain from attending the clinical area if any condition would interfere with patient safety.

1. Standing / Walking - 75% to 95% of work day spent standing/walking on carpet, tile, linoleum, asphalt and cement while providing patient care.
2. Sitting - 5% to 25% of work day spent sitting while operating computers, answering the telephone, writing reports, reviewing computer printout, charting, and gathering data.
3. Lifting - 10% to 15% of work day spent floor to knee, knee to waist, waist to waist and waist to shoulder level lifting while handling supplies, handling IV bottles, using trays, charting patient information, assisting with positioning and transferring patients.
4. Carrying - Up to 65% of work day spent carrying at waist level miscellaneous patient supplies.
5. Pushing / Pulling - Up to 40% of work day spent pushing/pulling patient care equipment.
6. Climbing - Up to 25% of work day spent climbing stairs going to and from other departments, clinics, office, and homes.
7. Balancing - Up to 25%, see climbing.
8. Stooping / Kneeling - Up to 10% of work day spent stooping/kneeling while retrieving medications from refrigerator, loading tray from supplies on lower shelves, using lower shelves of cart, stocking shelves, and retrieving items from bedside stands, bathrooms, storerooms, and providing patient care.
9. Bending - Up to 20% of work day spent bending at the waist while performing patient checks, gathering supplies, assisting with patient positioning, priming IV tubing, adjusting patient beds, adjusting exam table, tying and untying patient restraints, bathing patients, emptying tubes, and retrieving patient belongings.
10. Crawling - Up to 2% retrieving patient belongings.
11. Reaching / Stretching - Up to 35% of work day spent reaching/stretching while hanging IV bottles, checking IV solutions, gathering supplies, operating the computer, disposing of dirty needles in containers, plugging in tubing over bed, assisting with patient positioning, connecting equipment and retrieving patient files.
12. Handling - Up to 90% hand-wrist movement, hand-eye coordination, simple firm grasping required.
13. Fingering - Up to 90% fine and gross finger dexterity required.
14. Feeling - Up to 90% normal tactile feeling required. Sensitivity to heat, cold, pain, pressure, etc.
15. Twisting - Up to 15% of work day spent twisting at the waist while gathering supplies and equipment, operating equipment, and performing patient care.
16. Talking - Up to 95% average ability required. Fluent in English. Ability to communicate with wide variety of people and styles, ability to be easily understood.
17. Hearing - Up to 95% ability to hear and interpret many people and correctly interpret what is heard; i.e., physicians' orders whether verbal or over telephone, patient complaints, physical assessment, fire and equipment alarms, patient call bells, paging system, etc.
18. Seeing - Up to 95% acute visual skills necessary to detect signs and symptoms, coloring and body language of patients, color of wounds and drainage, infiltrated IV sites, and possible infections anywhere, interpret written work accurately, read characters and identify colors.
19. Smelling - Up to 95% acute olfactory skills to detect signs and symptoms of infection, bleeding, acidosis, smoke, fire, noxious chemicals, and/or gasses.

Essential Cognitive Learning Skills

1. Possess critical thinking abilities sufficient for clinical judgment: the ability to assess patient status and make appropriate clinical decisions regarding course of action within given time constraints.
2. Effectively synthesize clinical data from a variety of sources including written, verbal, and observational (assessment).
3. Prioritize nursing care for needs of multiple patients simultaneously.
4. Demonstrate independence in reasoning and decision making based on written, verbal, and observational data.
5. Solve practical problems and deal with a variety of variables in situations where only limited standardizations exist.
6. Perform mathematical calculations for medication preparation and administration.

Essential Communication Skills

1. Communicate clearly, verbally, nonverbally and in writing, demonstrating appropriate grammar, vocabulary, and word usage.
2. Interact effectively on an interpersonal levels with clients, families, and groups from a variety of social, cultural, emotional, and educational backgrounds.
3. Function effectively under stress.
4. Provide client teaching in a variety of modalities including written, oral, and demonstration.
5. Receive instruction verbally, written, and by telephone; interpret and implement.
6. Demonstrate appropriate control of affective behaviors, verbal, physical, and emotional levels to ensure the emotional, physical, mental, and behavioral safety in compliance with ethical standards of the American Nursing Association.

GAVILAN NURSING PROGRAM UNIFORM GUIDELINES

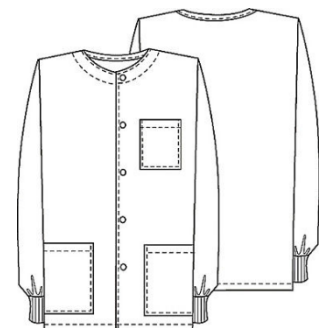
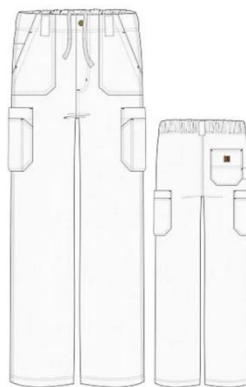
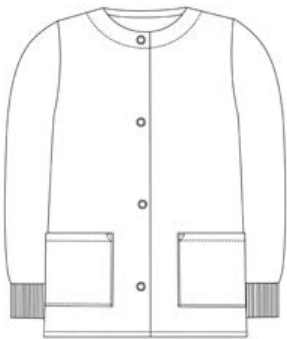
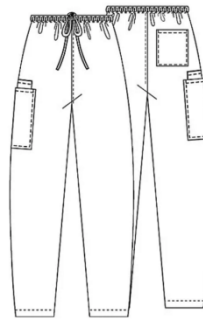
Scrub top: Royal blue V-neck

Scrub bottom: Royal blue elastic or drawstring waist

Jacket: White, snap front, no collar

Shoes: White

Examples:



You are not required to purchase your uniform from these vendors, this is a recommendation.

Absolutely! Uniforms

800 S. Bascom Ave San Jose, Ca 95128	580 S. Murphy Ave Sunnyvale, Ca 94086
Phone: (408) 297-3900 Fax: (408) 297-7652	Phone: (408) 245-6182 Fax: (408) 245-6183

Phone: (831) 753-6440
Fax: (831) 753-9640

**You're
#1
with us!**

SCRUBS FOR US
Professional Medical Uniforms
Medical Instruments & Accessories

Felicia Escobedo
Owner

317 W. Market Street
Salinas, California 93901

ITS *Independent Toxicology Services*

Drug Testing • Breath Alcohol

Phone (408) 924-0184
Fax (408) 924-0185
2400 Moorpark, Suite 113
San Jose, CA 95128

Halle Weingarten

**SOUTH VALLEY
BUSINESS SERVICES**

 OWNER

66 1ST ST STE B
GILROY, CA 95020
408-842-8055 408-842-8068 FAX

WWW.SOUTHVALLEYSVCS.COM



Gina Horwood
Assistant Manager

T. (408) 848-4400 F. (408) 846-7148
7483 Monterey Street, Gilroy, CA 95020
www.gilroymedicalsupply.com

You are not required to complete your livescan here, this is a recommendation.

APPOINTMENT DIRECTIONS

Make an appointment for prompt service-
Use the convenient **Website** to make your Personal
appointment: www.sccsheriff.org

Customers who do not have access to the internet may
make an appointment by phone at any of our locations

Please remember to bring your forms and a valid ID to
your appointment.

Cash or Checks only accepted for fees.

LIVES SCAN LOCATIONS

Headquarters

55 West Younger Ave
San Jose, CA 95110
(408) 808-4760

South County Substation

80 Highland Ave, Bldg K
San Martin, CA 95046
(408) 686-3651

West Valley Station

1601 S. De Anza Blvd
Cupertino, CA 95014
(408) 868-6614

Stanford University DPS

711 Serra St
Stanford, CA 94305
(650) 725-2499

Directions for making Live scan Appointments online

Log on to: www.sccsheriff.org

Click on **Services**

Click on **Fingerprint Services**

Choose **Make a Fingerprint Appointment Here**

Website is a secure site. All information requested with an * is required.

Use the Tab Key (not the enter key) to move from box to box.

Do not use any punctuation marks such as periods, commas or hyphens. Use numbers and letters only.

Some boxes have help information available. Point your mouse over the box for help information to appear.

Obtain ORI#, Mail Code, and Billing# (if applicable) from your agency.

When choosing a date and time, times shaded out are taken.

Print a copy of the appointment confirmation page & 3 copies of the applicant profile page.

*If you are unable to print your forms, we will print them at the time of your appointment.

Or call the location of your choice for phone appointment if you do not have internet access.

NO WALK-INS PLEASE **Cash or checks only accepted for fees.** **No Debit or Credit cards** **No \$100 bills**

Livescan Fee is \$52.00 cash exact or check for Gavilan C.N.A class

Santa Clara County, Office of the Sheriff
55 W Younger Ave
San Jose, CA 95110



Civil Division **(408) 808-4800**
Vehicle Releases **(408) 808-4404**
Operations Desk **(408) 808-4401**

FINGERPRINTING/LIVE SCAN REIMBURSEMENT FORM

Student Name: _____ G# _____
Last Name First Name M.I.

Student's Main Phone Number (____) _____

****IMPORTANT INFORMATION ABOUT YOUR ADDRESS****

In order to avoid delay, please be sure that the address you include on this form matches the address you have listed on Self Service Banner. If you need to update your address, please update it online at mygav.com or at the Admissions and Records Office.

Address: _____
Street Number Street Name Apt # City State Zip

Live Scan Site: _____

Live Scan Fee: \$ _____ Live Scan Date: _____

ATTACH
ORIGINAL
RECEIPT
HERE