



**LOS ANGELES COUNTY COLLEGE OF NURSING AND ALLIED HEALTH
NURSE ASSISTANT CERTIFICATION TRAINING PROGRAM APPLICATION**

APPLICANT INFORMATION:

(print/type legibly, all items must be completed)

Last Name: _____ First Name: _____

Employee Number (County employees only): _____ Department: _____ Area: _____

Manager/Supervisor: Name: _____ Contact Phone #: _____

ADDRESS:

Number and Street: _____ Apt. #: _____ City: _____ Zip Code: _____

Date of Birth: _____ Gender: F _____ M _____

Race/Ethnicity:

- American Indian or Alaska Native Asian Black or African American
 Hispanic or Latino Native Hawaiian or Other Pacific Islander White Two or more

CONTACT INFORMATION:

Email: _____ Phone #: _____ Emergency Phone #: _____

SCREENING FOR CRIMINAL CONVICTION:

Have you ever been convicted by **ANY COURT** of a crime other than a minor traffic violation? Yes: ___ No: ___

If you answer "YES" to this question, you must provide pertaining information to the California Department of Public Health and wait for their clearance before starting this training program.

Title XXII, California Code of Regulations Part 71828, Section (c), prohibits a student practicing on patients if the student has been convicted of crimes which could present a danger to patients.

Falsification of any section of the Nurse Assistant Certification Training application may result in adverse action pursuant to the Health and Safety Code, Section 1337.8.

TELL US WHY YOU ARE INTERESTED IN THE NURSE ASSISTANT CERTIFICATION TRAINING PROGRAM:

PERSONAL/WORK REFERENCES:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Applicant's Signature: _____ **Date:** _____

For Administrative use only. **Received by:** _____ **Date:** _____ **Time:** _____