



BASIC NURSE ASSISTANT PROGRAM-SPRING 2024

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****Email is the BEST way to reach Dr. Gray****

COURSE INFORMATION

The Basic Nursing Assistant Program is a one semester program and consists of one course:

NAS 100: Basic Nurse Assistant= 6 credit hour

Spring 2024 Semester: January 22, 2024- May 15, 2024

On-Campus LECTURES: Mondays and Tuesdays 2:30-4pm

On-Campus LABS: Wednesday and Thursday 2:30-4:30p

Off-Campus CLINICALS: Saturdays 2/24/24 thru 4/20/24 (total of 7 Saturdays) 7:00 A.M. – 3:30 P.M.

CLINICAL AGENCIES

Area nursing homes and hospitals will be used for Clinicals. Sites to be determined. Location is within a 15-20 mile radius. Students are responsible for getting to and from clinical.

PROGRAM POLICIES

ABSENCES

There are **NO ABSENCES** allowed. **ALL STUDENTS ARE REQUIRED TO MAKE UP ABSENCES.**

PLEASE E-MAIL your clinical instructor regarding your make-up assignment.

THERE ARE NO ALLOWABLE ABSENCES IN THE CLINICAL SETTING.

The State of Illinois requires **ALL** students have 40 hours minimum of clinical time. Our Program is 60 hours. If you should miss a clinical day and you are passing with an 80% or better, you will be expected to make up the clinical absence when space is available. Clinical **begins at 7:00 a.m.** Those who arrive late **WILL** be sent home and this will be considered an absence.

METHOD OF GRADING: Examinations, are the bulk of your grade. There will be assigned homework from the associated book which is your “ticket to class”. If your homework is not completed you will be sent home and this will count as an absence. Lab and clinical is **PASS or FAIL.** Students must have an 80% or better to pass this course.

NURSING ASSISTANT CERTIFICATION: Having completed NAS 100 with an 80% or better, only means you have completed an approved program by the State of Illinois. The only way that you become Certified by the State is to take the Illinois Nurse Aide Competency Exam within a year of course completion. The exam is currently **\$85.00.**

PROGRAM PRE-REQUISITES

1. Complete on-line Triton College Admission Application by visiting www.triton.edu, click “Apply Now”
 - a. Select Dual Credit/Dual Enrollment Application
2. Complete the college placement test (Reading, Writing, Math) prior to course registration.
 - a. A qualifying Reading and Writing college level placement score is required to enroll in NAS-100.
 - b. TRITON COLLEGE PLACEMENT TESTING CENTER, ROOM A-126, x3252
 Monday – Thursday 8:00 am - 8:00 pm
 Friday 8:00 am - 4:00 pm
 Saturday 9:00 am - 2:00 pm
 You do not need to make an appointment to take the Placement Test. You do need to be there prior to the starting time. Testing Services will begin at 8:30 am on Monday-Friday and 9:30 am on Saturdays. Please arrive at least 2 hours prior to closing to allow enough time to complete the assessment. PLEASE CONTACT THE PLACEMENT TESTING CENTER FOR CURRENT HOURS.
3. Ability to speak, read, write and understand the English language as determined by designated staff.
4. Valid U.S. Social Security Number.
 - a. An ITIN number is a tax processing number issued by the IRS beginning with the number 9 and with 7 or 8 as the fourth digit; this number is not allowed per the Illinois Department of Public Health (IDPH).

5. All items below must be completed before the start of class unless stated otherwise. Failure to submit all items below prior to the start of class, the student will be dropped from the course.

*Cost is an approximate estimate and varies depending on the vendor.

Item	Cost*	Submission	Where to go
Healthcare Worker Background Check Form	Free	Submit form immediately but no later than 1/8/24 to Department Chair or program secretary.	Can not start program without completing this step. Form attached to this packet.
Finger Printing	\$75-80	You will be sent a Live Scan form once your Healthcare Worker Background Check form is entered into the system by the Nursing Assistant Department.	Select vendor listed on the Live Scan form to complete finger printing.
Castle Branch Immunization Documentation Tracker and Drug Screen	\$66	Setup Castlebranch account and enter code TX63dtim	https://www.castlebranch.com/ Purchase Triton College - Nursing Assistant
CPR (must be American Heart Association BLS)	\$60-90	Upload to Castlebranch	Class offered through Triton’s Continuing Education Department. https://www.triton.edu/academics/continuing-education/center-for-health-care-professionals/cpr-for-healthcare-providers/
Medical Insurance	Varies	Upload to CastleBranch	Our clinical sites require students to have hospitalization insurance. For those students that do not have hospitalization insurance with your parents or through your employer, you may purchase a short-term medical insurance policy through any of the following two (2) companies: 1. First Agency, Inc. 2. Health Insurance Marketplace Signing up for the \$5,000.00 deductible will be at a lower rate/premium.

6. Other Program Related Expenses

TEXTBOOK: Mosby's: Textbook for Nursing Assistants, 10th edition, approx. \$143.00 which includes the Workbook & DVD's. Available at the Triton College Bookstore, B building. **Required first day of class.**

UNIFORM: for both males and females. The uniform color is wine/raspberry/burgundy/maroon. Your uniform cannot have any lettering or other coloring on it. You need one (1) complete uniform for clinical. You need 2 clinical tops; **one will be worn to ALL labs on campus.** Your uniform tops and bottoms must be kept clean and neat at all times.

Uniform tops with our Triton patch & a uniform bottom, may be purchased at the Triton College Bookstore, B building starting at approximately \$37.00.

Uniforms are also available at: Wal-Mart, Amazon or Work-N-Gear (9th & North Ave/Melrose Park).

NAME TAG: **Once clinical starts,** you are required to have your name tag on your uniform. Your name tag is to be ordered in the Triton College Bookstore, B building for approximately \$9.00.

WATCH: Watch with a second hand required for the **first day of lab.**

SHOES: Gym shoes required for the **first day of clinical.**

7. *Physical Exam and Immunization Requirements must be completed by 02/05/2024 or you cannot start clinicals.*

Item	Cost*	Submission	Where to go
Physical Exam	Can be covered by insurance or out of pocket	Upload to CastleBranch	Your PCP or a clinic.
TB Testing	Can be covered by insurance or out of pocket	2-step PPD or QuantiFERON Gold Upload to CastleBranch	Your PCP or a clinic
Flu Shot	Can be covered by insurance or out of pocket	Upload to CastleBranch	Your PCP or a clinic, or your local pharmacy
COVID vaccination or Booster	Can be covered by insurance or out of pocket	Upload to CastleBranch	Your PCP or a clinic, or your local pharmacy
Vaccination: MMR Varicella Hepatitis B Tdap (Tetanus, Diphtheria, Pertussis)	Can be covered by insurance or out of pocket	Upload to CastleBranch	Your PCP or a clinic ** it may be better to get blood titers of MMR, varicella and Hep B to show proof of immunity



Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

- Race
- A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
 - B** Black or African American (Not Hispanic or Latino)
 - H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
 - I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
 - U** Of undeterminable race. Of Untold mixture.
 - W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

(Signature)

(Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

(Signature of Parent or Guardian when applicable)

(Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****