Community Health Aide
Basic Training Application

Application to Session # _____
Date this application updated: _____

To be completed by the field supervisor and the CHA. This application must be received by the training center at *least four weeks* before the *start* of the session. Please complete both sides of the form.

Name: _____ _____
Last First MI CHAPCB Certificate #

Mailing address: _____
PO Box or Street City State Zip

Birth date: _____ Phone #'s: _____
Cell Home Clinic Fax

CHA email address: _____

Training levels of health care providers in clinic: _____

Employer: _____ Village: _____ Population: _____

Field Supervisor: _____ Field Supervisor Phone: _____

Field Supervisor email: _____

Field Supervisor Address: _____
PO Box or Street City State Zip

CHAP Director's name: _____

CHAP Director's phone: _____ Director's email: _____

EDUCATION:

HS graduate/GED date:_____ or Highest grade completed: ____ Post high school courses or degree: _____
TABE "9-10D"Test: Reading Grade Level: ____ Math Level: ____ If not 9-10D: specify which TABE test:_____

CHAP Medical Math Assessment completion date: _____ CHAP Medical Math Checklist attached: ☐ Yes ☐ No

EMS Training: ETT ***or*** EMT	ETT Exp:		EMT Exp Date:		
Pre-Session Course	Date: Location:				
Basic Training	Month/Year Completed & Location	Pass	No Pass	CHAP CB Certified	Cert Exp Date
Session I				☐ Yes ☐ No	
Session II				☐ Yes ☐ No	
Session III				☐ Yes ☐ No	
Session IV				☐ Yes ☐ No	

Training /Classes since last session: _____

_____

Other Work Experience: _____

_____

LANGUAGE:

What Native language is spoken in your village? _____ Do you speak this? ☐ Yes ☐ No

eCHAM TRAINING:

Applicant has completed eCHAM Training (online, in person, or on demand) ☐ Yes ☐ No Date of Training_____

Applicant has completed the eCHAM Core Competencies Checklist. ☐ Yes ☐ No Date of Completion_____

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CHA: _____

PASSED BACKGROUND CHECK Date: _____ Employer's Signature of Affirmation: _____

HEALTH SCREENING: Results required before CHA can see patients:

Do NOT send immunization/chart records.

IMM/TEST	Hep B	MMR		Varicella (Chickenpox)		Td/Tdap in past 10 yrs	PPD within past 12 months
Date of Vaccine or Hx of Disease **OR**	**Date of Immunization:** **#1** _____ **#2** _____ **#3** _____	**Date of Immunization:** **#1** _____ **#2** _____		**+Hx** ☐ **Yes** ☐ **No**	**Imm. Date:** _____	**Date:** _____	**Date administered:** **Date Read:** _____ **Result: #mm**
Results of Titer:	**Date:** ☐ **Immune** ☐ **Not Immune** ☐ **Carrier**	**Rubella TITER:** ☐ **Immune** ☐ **Not Immune** **(German Measles)**	**Rubeola TITER:** ☐ **Immune** ☐ **Not Immune** **(Measles)**	**TITER: (if no Hx/Imm):** ☐ **Immune** ☐ **Not Immune**			**If + PPD/TB Hx, Survey Attached?** ☐ **Yes** ☐ **No**

Influenza vaccine (highly recommended) ☐ Yes ☐ No Date of last influenza vaccination: _____

Hearing Problems? ☐ No ☐ Yes Corrected? ☐ No ☐ Yes (Bring hearing aid and/or augmented stethoscope)

Vision Problems? ☐ No ☐ Yes Corrected? ☐ No ☐ Yes (Bring glasses/contacts)

Any Allergies? ☐ No ☐ Yes If yes, describe the reaction: _____

Please list any other issues that might impact this CHA's ability to complete the session: _____

_____

STATEMENT OF INTENT:

Have you ever left a session early for any reason? ☐ No ☐ Yes. If yes, please attach a written and signed statement identifying the problem and resolution. Include a statement of your commitment to completion of this next session.

EMERGENCY INFORMATION: Person to notify in case of an emergency.

Name: _____ Relationship: _____

Address: _____

Phone: _____

Cell Day Evening

Contact [if any] in community of Training Center:

Name: _____ Relationship: _____

Address: _____

Phone: _____

Cell Day Evening

AUTHORIZATION TO RELEASE INFORMATION:

I authorize release of the personal, health and training information requested on this form from my employer and/or health care provider to any CHA Training Center at which I request training. I recognize that this information may be shared between Training Centers and the clinics in which I work as part of my permanent training record. I recognize that this information will be used to plan and evaluate my training and to protect my health and safety and that of the patients I see while I am in training.

Signed by CHA: _____ Date: _____

Reviewed by Supervisor: _____ Date: _____