

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 <i>or</i> 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				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Session II				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Session III				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Session IV				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Training /Classes since last session: _____

Other Work Experience: _____

LANGUAGE:

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

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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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Imm. Date: _____ _____	Date: _____ _____	Date administered: _____
	Results of Titer: 	Date: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune <input type="checkbox"/> Carrier	Rubella TITER: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune (German Measles)	Rubeola TITER: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune (Measles)	TITER: (if no Hx/Imm): <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune		Result: _____ #mm If + PPD/TB Hx, Survey Attached? <input type="checkbox"/> Yes <input type="checkbox"/> 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)

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: _____