Community Health Aide Basic Training Application

Application for Session #:	
Date 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				CHAPCB Certificate #			
Mailing address:									
PO B	ox or Street		City		S	tate	Zip		
Birth date:	Phone								
		Cell	Hor	ne	Clinic		Fax		
CHA email address:									
Training levels of hea	alth care pro	viders in clinic:							
Employer:		Village:			Population:				
		Field Supervisor Phone:							
Field Supervisor ema	il:								
Field Supervisor Add									
	PO Box	or Street C	City		State		Zip		
CHAP Director's nar	ne:								
CHAP Director's pho	one:	Direc	tor's ema	ail:					
EDUCATION:									
HS graduate/GED da	te:	or Highest grade complete	ed:	Post high	school cour	ses or degre	e:		
_		ade Level:Math Leve		_		_			
		t completion date:							
EMS Training: ETT	or EMT I	EMT ETT Exp:			EMT Exp Date:				
Pre-Session Course	Date:	Location:			1				
Basic Training	Month/Ye	ar Completed & Location	Pass	No Pass	CHAP CH	CHAP CB Certified Cert Exp			
Session I					Yes	No			
Session II					Yes	No			
Session III					Yes	No			
Session IV					Yes	No			
Training/Classes sinc	e last sessio	n:							
Other Work Experier	nce:								
Native language is sp	oken in you	r village:		Do you	ı speak this?	Yes	No		
Completed eCHAM	•	Yes - Date of training:							
_	-	No - Date training will		eted:					

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Community Health Aide Basic Training Application

				Application for Session #:				
					Date ap	plication upd	ated:	
				СНА				
DACCEDI	DACUCDOI	IND CHECK D	neta. Emmla		A:			
					of Affirmation: e before attending trai			
			regional training cent	-		J		
			ired vaccinations prior		ing.			
Vaccine or TEST	Нер В	MMR	Varicella	Td or Tdap in past 10 yrs	TB screening	Flu	COVID	
	Vaccine dates:	Vaccine dates:	+ Hx: Yes No	Date:	Date:	Vaccine Date:		
	1:	1:	Vaccine dates:		PPD: Blood test: Result:		1:	
	2:	2:	1:		If +PPD or hx TB, survey		2:	
	3:		2:		attached? Yes No		Booster:	
Results of Titers	Нер В		MMR		Vision Problems	Hearin	g Problems	
Titels	Date:	Rubella Titer:	Measles Titer:	Mumps Titer:	Yes No	Yes No		
	Immune	Immune	Immune	Immune	Corrected: Yes No	Corrected: Y		
	Not Immune Carrier	Not Immune	Not Immune	Not Immune	Bring glasses and/or contacts	stethoscope	ds and/or augmented	
Allergies:		Zes If ves. desc	cribe the reaction:					
N95 FIT 7					N95 <u>:</u>			
Please list	any other iss	ues that might if	npact this student's	ability to comple	te the session:			
STATEM	ENT OF INT	TENT:						
•		•	•	• • •	olease attach a written	_		
statement	identifying th	e problem and r	esolution. Include a	statement of you	r commitment to com	pletion of the	his next session	
EMEDŒ	NOVINEOI	OMATION, D.	44: c :	.	_			
			rson to notify in case	<i>C</i> ,				
					lationship:			
Phone:	Cell			Day		Evening		
		nunity of Traini		Day		Lvening		
-	• -	•		Relations	ship:			
					•			
r none	Cell			Day		Evening		
AUTHOR	ZIZATION T	O RELEASE I	NFORMATION:					
					on this form from my			
					gnize that this informa			
					anent training record. nealth and safety and t			
	in training.	i io pian anu eva	nuace my training an	id to protect my i	icatin and saicty and i	mai or me p	anoms 1 300	
	C			Da ⁻	te:			
					te:			

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