

OSWEGO COUNTY BOCES  
ADULT CAREER EDUCATION / CAREER SERVICES OFFICE  
179 County Route 64, Mexico, New York 13114  
(315) 963-4256

## APPLICATION PROCEDURE FOR NURSE ASSISTANT PROGRAM

It shall be the policy of the Board of Cooperative Educational Services of Oswego County to provide equal opportunities for all persons affected by the myriad of operations of the Oswego County BOCES without regard to age, race, marital status, parental status, color, creed, religion or national origin.

### **To Get Started:**

Fill out the Student Application Form (including the essay) and the Medical History Form "A" and **submit** both forms to the Adult Education Career Services Office at the above address.

Call 963-4256 to schedule an entrance test for the program, the Test of Adult Basic Education (the TABE). You cannot enter the program without having taken and passed the TABE. You will be contacted with your test results. If you do not pass the test the first time, remedial help is available and you can take the test again when you are ready. TABE test results are valid for one year.

### **Immediately After Applying:**

**Schedule** a physical and have the physician complete the BOCES Physical Form B. This is the only form that will be accepted. **The signed, completed physical form must be submitted to the Career Services Office before you can be accepted into the program.** The date on the physical form cannot be more than one year prior to the start date of the program.

**Contact** your physician or one of the Immunization Clinics in Oswego County (list enclosed) to complete the Immunization Record Form. **The signed, completed immunization form must be submitted to the Career Services Office before you can be accepted into the program.** Please read the form carefully. Strict adherence to dates and times of shots is mandatory.

**Distribute** the two reference forms provided in the packet to the references you listed on your Student Application Form. **The forms must be returned directly to the Career Services Office and must be received before your Admissions Interview.** Telephone responses are not accepted. References must be non-related persons, and boyfriends or girlfriends are not appropriate. If you have worked within the last three years, one reference must be from an employer.

### **After passing the entrance (TABE) test:**

**Once you pass the entrance test** and submit your 1.) Student Application, 2.) Medical History Form A, 3.) Essay, and 4.) Two References, you will be notified of your scheduled appointment for an Admissions Interview. The Admissions Interview is a requirement for admission into the program and you will not be scheduled until all of the items listed above are in your file. If you cannot keep this appointment, please call (315) 963-4256 to cancel and/or reschedule.

### **Finally:**

**Receive** a letter of decision from the admissions committee. All completed admissions files are reviewed by an admissions committee and not everyone who applies is accepted into the program. Prospective students should not assume they have been accepted until they receive a letter of acceptance.

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**STUDENT APPLICATION FORM**

**DIRECTIONS:** Please write or print clearly. Answer each question on **both sides**.

**PART I**

Program Title \_\_\_\_\_ Social Security# \_\_\_\_\_  
Name \_\_\_\_\_ Maiden or Prior Name \_\_\_\_\_  
Address \_\_\_\_\_  
(STREET or RURAL ROUTE & BOX #) (CITY) (STATE) (ZIP CODE)  
Phone Numbers: Home \_\_\_\_\_ Message or Work \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Highest High School Grade Completed? (Circle one) 8 9 10 11 12  
High School Diploma? \_\_\_\_\_ Yes \_\_\_\_\_ No Year: \_\_\_\_\_  
Name of School: \_\_\_\_\_  
GED? \_\_\_\_\_ Yes \_\_\_\_\_ No Year: \_\_\_\_\_  
Any education beyond High School? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please list name and address of school and dates attended. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART II**

Work Experience: (Job held within last 12 months)

1. Type of Work Performed: \_\_\_\_\_
2. Length of Time: \_\_\_\_\_
3. Name & Address of Employer: \_\_\_\_\_
4. Are you still employed? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, why did you leave this employment? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employment Prior to the Above Listing:

Place of Employment	Title/Duties	Dates of Employment
_____	_____	_____
_____	_____	_____
_____	_____	_____

References: Both references must be non-related persons. If you have worked within the last three years, one reference must be an employer.

1. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
                     (STREET or RURAL ROUTE & BOX #)      (CITY)                      (STATE)                      (ZIP CODE)
2. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
                     (STREET or RURAL ROUTE & BOX #)      (CITY)                      (STATE)                      (ZIP CODE)

**PART III**

1. On a separate piece of paper, please write in your own words a legible hand-written 250-word essay explaining why you want to become a nurse aide.
2. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?  
       \_\_\_\_\_Yes \_\_\_\_\_ No
3. Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?  
       \_\_\_\_\_Yes \_\_\_\_\_ No

**AFFIRMATIVE ACTION POLICY**

It shall be the policy of the Board of Cooperative Educational Services of Oswego County to provide equal opportunities for all persons affected by the myriad operations of the Oswego County BOCES without regard to age, race, sex, marital status, disabilities, creed, religion or national origin.

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It is understood and agreed that all the information I have provided on this application is true, correct and complete. If accepted for training, I understand that any misstatement or omission of fact on the application may result in my dismissal.

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE

OSWEGO COUNTY BOCES  
Career Services Office  
179 County Route 64, Mexico, New York 13114

**MEDICAL HISTORY FORM "A"**

DIRECTIONS: Please write or print clearly. Answer each question on both sides.

Student's Name: \_\_\_\_\_

Sex:  Female  
 Male

Date of Birth: \_\_\_\_\_

**CURRENT HEALTH**

Please provide details/dates for the following:

1. Present health status (check one):  Poor  Fair  Good  Excellent

2. Are you presently being treated for any condition or disease?  Yes  No  
If yes, state details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Name/address of Health Care Professional treating you:

\_\_\_\_\_  
\_\_\_\_\_

4. Date of last health exam: \_\_\_\_\_ Last dental exam: \_\_\_\_\_

5. List current medications, including over-the-counter drugs, vitamins, prescribed drugs:

\_\_\_\_\_  
\_\_\_\_\_

6. Allergies (check all that apply and provide details):

Drugs

Foods

Contact Substances

Environmental Factors

*I have never abused or been addicted to depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.*

Yes, I have. If yes, explanation:

No, I have not.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

HEALTH HISTORY

Have you or any member of your immediate family ever had:

	No	Yes*	Self	Family Member
Head or spinal injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures, fits, convulsions or fainting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extensive confinement by illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suffering from any other disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent defect from illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any other nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\*If you answered "yes" to any of the above questions, please explain:

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*The law prohibits discrimination because of age, race, sex, marital status, disabilities, creed, religion, or national origin and requires affirmative action in the hiring of the handicapped.*

*The information that I have provided on this questionnaire is accurate to the best of my knowledge. I have read, understand, and agree that BOCES will require a medical examination and if further medical information is required, I agree to provide a signed release statement as requested to secure the information.*

*This and other medical information will be held in strict confidence. It will be released only where required by law. Non-confidential information regarding work restrictions relating to job assignment will be provided to management and personnel.*

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Signature of Applicant

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Date

**Oswego County BOCES**  
 Career Services Office  
 179 Co. Rte. 64, Mexico NY 13114

**Nurse Assistant Program**  
**PHYSICAL EXAMINATION FORM "B"**  
 (to be completed by your physician)

Applicant's Name	SS#	Age	Date of Birth
Address	City	State	Zip

**PHYSICIAN'S CERTIFICATE**

I Certify That I Have Examined \_\_\_\_\_  
 Please Print Applicant's Name

He/She is physically qualified...  He/She is not physically qualified...   
 to participate in the Nurse Assistant program which requires the physical ability to withstand prolonged periods of standing and walking; lift 50 pounds; hear and see accurately; calculate proportions, determine size; perform measurements, check movements, observe relationships; and react quickly in an emergency situation. Finger dexterity and hand/eye coordination are also required; the ability to follow written and oral directions and to communicate orally and in writing; freedom from communicable diseases and freedom from addiction to alcohol or drugs.

Examination Date	Print Name of Examining Doctor	Signature of Examining Doctor
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HEALTH HISTORY : Physician, please circle YES or NO to indicate if applicant has or has not experienced any of the following symptoms or diseases. If YES, please indicate date.

	DATE		DATE	
YES/NO	Decreased Hearing		YES/NO	Ear Infections, Frequent
YES/NO	Dizzy Spells/Fainting Spells		YES/NO	Head Injuries
YES/NO	Vision Problems		YES/NO	Eye Infection, Frequent
YES/NO	Nose Bleeds, Recurrent		YES/NO	Hay Fever/Allergies
YES/NO	Upper Respiratory Infection		YES/NO	Asthma/Wheezing
YES/NO	Chest Pain		YES/NO	Irregular Pulse
YES/NO	High Blood Pressure		YES/NO	Heart Murmur/Palpitations
YES/NO	Varicose Veins/Phlebitis		YES/NO	Loss of Appetite/Weight Loss
YES/NO	Gastrointestinal Disorders		YES/NO	Jaundice/Hepatitis
YES/NO	Hernia		YES/NO	Urine Infections, Frequent
YES/NO	Kidney Stones		YES/NO	Venereal Disease
YES/NO	Anemia		YES/NO	Cancer
YES/NO	Diabetes		YES/NO	Thyroid Disease
YES/NO	Convulsions/Seizures		YES/NO	Stroke
YES/NO	Headaches, Frequent		YES/NO	Arthritis/Rheumatism
YES/NO	Back Pain/Spinal Injury		YES/NO	Bone Fracture/Joint Injury
YES/NO	Gout		YES/NO	Skin Problems
YES/NO	Nervousness		YES/NO	Depression
YES/NO	Mental Illness		YES/NO	Menstrual Problems

Any Childhood Diseases (please list): \_\_\_\_\_

Describe any of the above symptoms or diseases circled "yes": \_\_\_\_\_

List any injuries/illnesses and/or operations: Year Year  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications applicant is now taking or has taken in past two years: \_\_\_\_\_  
 \_\_\_\_\_

General Appearance and Development (circle one): Good Fair Poor

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Temp. \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_  
 Blood Pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_

Throat: \_\_\_\_\_  
 \_\_\_\_\_

Thorax: \_\_\_\_\_  
 \_\_\_\_\_

Heart: \_\_\_\_\_  
 \_\_\_\_\_  
 If organic disease is present, is it fully compensated? \_\_\_\_\_

Lungs: \_\_\_\_\_  
 \_\_\_\_\_

Abdomen: \_\_\_\_\_  
 Scars \_\_\_\_\_  
 Abnormal Masses \_\_\_\_\_  
 Tenderness \_\_\_\_\_

Hernia: Yes No If so, where? \_\_\_\_\_ Is truss worn? Yes No

Gastrointestinal: Ulceration or other disease? Yes No

Genito-Urinary: Scars \_\_\_\_\_  
 Urethral Discharge \_\_\_\_\_

Reflexes: Romberg \_\_\_\_\_  
 Pupillary Light (R) (L) Right Knee Jerks Normal Increased Absent  
 Accommodation Right \_\_\_\_\_ Left \_\_\_\_\_ Left Knee Jerks Normal Increased Absent

Musculoskeletal System: Upper \_\_\_\_\_  
 Lower \_\_\_\_\_  
 Spine \_\_\_\_\_

REMARKS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## STUDENT IMMUNIZATION RECORD FORM

Student Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Student Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

NYS Public Health Law requires post-secondary students to show protection against measles, mumps, and rubella:

Please note: MMR Vaccine is recommended for all measles vaccinations to provide increased protection against all three vaccine-preventable diseases: measles, mumps and rubella.

- Individuals should not be pregnant at the time they receive the vaccine.
- Individuals should not become pregnant for 3 months after receiving the MMR vaccine.
- Individuals should discuss questions and concerns with their physician.

**REQUIRED: Measles (Rubeola) Immunity:** Must have one of the following:

- Two (2) dates of Measles (Rubeola) Immunization (both must be given after 1967 and on or after the first birthday: 1) \_\_\_\_\_ 2) \_\_\_\_\_
- or - Date of Measles Titer: \_\_\_\_\_ Results: \_\_\_\_\_
- or - Date of physician-diagnosed measles disease AND signature of diagnosing physician: \_\_\_\_\_  
Date Signature

**REQUIRED: Rubella (German Measles) Immunity:** Must have one of the following:

- Date of at least one (1) Rubella Immunization (must be on or after first birthday): \_\_\_\_\_
- or - Date of Rubella Titer: \_\_\_\_\_ Results: \_\_\_\_\_  
NOTE: Physician diagnosis is not acceptable for rubella immunity.

**REQUIRED: Mumps Immunity:** Must have one of the following:

- Date of at least one (1) mumps immunization (must be on or after first birthday): \_\_\_\_\_
- or - Date of Mumps Titer: \_\_\_\_\_ Results: \_\_\_\_\_
- or - Date of physician-diagnosed mumps disease AND signature of diagnosing physician: \_\_\_\_\_  
Date Signature

Additional vaccines and testing for Oswego County BOCES Health Occupations students:

**REQUIRED: Tetanus (TD):** Date of last booster (must be within last ten years): \_\_\_\_\_

**REQUIRED: Mantoux (PPD) Test** (must be no earlier than 2 months prior to start date of the class):  
Date of Mantoux: \_\_\_\_\_ Results: \_\_\_\_\_ Date Results Recorded: \_\_\_\_\_

**RECOMMENDED: Hepatitis B Vaccination Series:**

- For students choosing to have the Hepatitis B Series:  
Date of first shot: \_\_\_\_\_ Second shot: \_\_\_\_\_ Third shot: \_\_\_\_\_
- or - For students declining the Hepatitis B Series, please sign the following statement:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. *If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination at a later time.*

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

**IMMUNIZATION CLINICS\***

Vaccinations may be received by an Oswego County Resident for a small fee.

Immunizations and screening tests are available on a walk-in basis at the following locations:

Location:	Day of Week:	Month(s):	Time:
<u>Oswego</u> Preventive Health Clinic  County Health Dept. 70 Bunner Street	every Friday	every month	12:30-3:30PM
<u>Pulaski</u> Court House	every Friday	every month	9:00 to 11:00AM

\* Any questions regarding immunizations may be directed to:  
the Oswego County Health Department (315) 349-3545 or the Pulaski Health Clinic (315) 298-2233  
 Monday through Friday, 8:30 AM to 4:00 PM

OSWEGO COUNTY BOCES  
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**REFERENCE FORM**

**TO THE APPLICANT:** Please fill out your name, program and semester for which you are applying. Give one form to each of your references. Both must be non-related persons. If you have worked within the last three years, one reference must be an employer.

**NAME:** \_\_\_\_\_ **PROGRAM:** \_\_\_\_\_  
**SEMESTER** (please check):     Fall                     Spring             Summer

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**TO THE REFERENCE WRITER:**

The applicant listed above has applied for admission into our program. Please indicate how long you have known the above applicant and the capacity in which you have known them. Include any attributes they possess that would be valuable for the profession they are seeking. Additionally, please indicate any reservation you have regarding the applicant's ability to successfully complete the program. Please return promptly to the above address.

Reference writer's:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Organization: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Address: \_\_\_\_\_

Organization: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_