

Farmington Valley Certified Nurse's Aide Program

Application

Name _____

Date _____

Home

Address _____

E-mail

Address _____

Social Security Number _____ Date of Birth _____

Gender Male Female Are you a U.S. Citizen? Yes No

Phone Number _____

What is the highest level of education completed? _____

Name of Educational Institution _____

Year _____

Have you ever been convicted of a crime? Yes No If yes please explain briefly below

Job History:

Place of employment _____

Position _____

Start date _____ End date _____

Place of employment _____

Position _____

Start date _____ End date _____

Please list one professional and one personal reference:

*C.G. Nursing Services, LLC
Farmington Valley Certified Nurse's Aide Program
3 Forest Park Drive, 1st Floor
Farmington, CT 06032
Phone 860-255-7723 - Fax 860-470-3144*

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(Professional)Name_____ Phone_____

(Personal) Name_____ Phone_____

Questionnaire

Please tell us about yourself and why are you interested in becoming a CNA?

What qualities about yourself will make you a good CNA?

What do you know about Alzheimer's disease and dementia?

How will this program help you work towards your career goals?

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What are you hoping to learn from this program?

What are your strengths and your weaknesses as a student?

Do you have a Drivers License? Yes No (if no please explain your method of transportation)

How did you hear about this program?

- Online (Name) _____ Newspaper Friend
- School (Name of School) _____

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Discloser and Authorization for Background Investigation

I hereby authorize C.G. Nursing Services, LLC to order my background report. This report is pertaining to my enrollment into The Farmington Valley Certified Nurse's Aide Program. I am fully aware that this report may contain State and Federal criminal records, Police Records, Motor Vehicle records, Personal References, and Credit Report. I understand that I must pass the background report prior to being considered for the program/course. I authorize any Party or agency to disclose the above mentioned information to C.G. Nursing Services, LLC. These reports are ordered to ensure the safety of patients, students and staff on campus and in the clinical facility.

Name _____ Date of Birth _____

Social Security Number _____ Drivers License Number _____

Address _____

Other Names

Used _____

Signature _____

Date _____