WEBER STATE UNIVERSITY

SCHOOL OF NURSING

&

CONTINUING EDUCATION

APPLICATION
FOR
ADMISSION
- May 2015 -

Medication Aide Certificate Program Cohort #2

This application packet is for individuals that are being sponsored or self funding in the second Cohort of the Medication Aide Certificate Program at Weber State University.

It is recommended if you have questions to contact the Enrollment Director for the School of Nursing at rholt@weber.edu and identify yourself as a prospective student in the Medication Aide Certificate Program. E-mail will produce a quicker response but if necessary you can contact the Enrollment Director for the School of Nursing at (801)626-6753.

February 6, 2015

Dear Applicant:

We are pleased to hear of your interest in the new Weber State University (WSU) Medication Aide Certified (MAC) Program through the School of Nursing. This is program is offered through the School of Nursing and we encourage you to ask questions if you have them.

- Please read the enclosed information carefully. This packet contains **ALL** mandatory application requirements and deadlines.

- Submit all requested information prior to 4:30 pm of the posted application deadline -April 20, 2015. **Application packets that do not contain all the required information will be considered incomplete and will render your application unqualified.** Only on-time and **COMPLETED FILES ARE SENT TO BE REVIEWED FOR SELECTION CONSIDERATION.**

Again, we are pleased that you are interested in the Medication Aide Certificate Program offered by the School of Nursing at Weber State University.

I encourage you to contact our Enrollment Director at rholt@weber.edu or (801)626-6753 if you should have questions about the information in this application packet.

Sincerely,

Susan B. Thornock

Susan B. Thornock, Ed.D, RN
Chair, School of Nursing
Weber State University

WEBER STATE UNIVERSITY
SCHOOL OF NURSING
APPLICATION PACKET
FOR
MEDICATION AIDE CERTIFIED (MAC)

TO THE APPLICANT:

All Application Materials:

A-1 ☐ Sponsorship Agreement
(Self Funded Students must also have this document signed stating they have 2,000 hours of work experience as a CNA)
A-2 ☐ Demographics
A-3 ☐ Instructional Information
A-4 ☐ Statement on Student Policies
A-5 ☐ Release and General Indemnity
A-6 ☐ Health Insurance Form
A-7 ☐ Notice of No REFUND
A-8 ☐ Confidentiality Statement
A-9 ☐ CPR Form

Must all be returned in one packet by April 20, 2015.

We work off of postmarks as well as by being turned in by 4:30 p.m. on the application deadline day.

Return to: **Medication Aide Certified (MAC) Program**
C/O Robert Holt
School of Nursing
Weber State University
3875 Stadium Way Dept 3903
Ogden, UT 84408-3903

OR

Robert Holt
Marriott Building, RM#431
Weber State University - Ogden Campus

WEBER STATE UNIVERSITY
MEDICATION AIDE CERTIFIED (MAC) SPONSOR AGREEMENT FORM
& 2000 Hours of Documented Work Experience as a CNA in the last 2 years

The Medication Aide Certificate (MAC) Program requires that the potential student in the program receive Health Care Agency Support by verifying they have the 2000 hours of work experience as a CNA. Additionally students that are being sponsored by someone other than themselves need permission to apply and to be a sponsored student in this program. As a part of this support comes the approval from your administrator that you have at least 2,000 hours of work experience as a CNA (Certified Nursing Assistant) in the last two years.

Please have this form signed by your Human Resource Officer or Administrator.

Failure to have the signature of the sponsoring agency will prevent you from being approved for this program. Unless of course you are self-paying. If you are self paying you still need this form signed by HR personnel verifying your 2,000 hour of work experience as a CNA.

I acknowledge that following student has met with me about the Medication Aide Certified (MAC) Program and that our Agency Agrees to sponsor (pay tuition for this program) this student. The admitted Student is required to pay for the $35 Dollar Drug Test on their own as well as the cost of their own books [Unless Agency decides to reimburse the student for this cost]. The student will only be given directions for the Drug Test after gaining approval to be a sponsored student and being selected to begin the Medication Aide Certified (MAC) Program administrated by the Weber State University School of Nursing.

NAME OF STUDENT:_____

EMPLOYEE AT OUR FACILITY:_____
(Name of facility)

Approval to be considered for this program. Includes our support of the fact that this student has 2,000 hours of work experience as a CNA in the last two years.

_____
Administrator or Human Resource Officer Name

_____ _____
Signature Date

Contact Information: Phone Number: _____

E-mail:_____

Address:_____

NON SPONSORD STUDENTS STILL NEED TO SUBMIT THIS FROM THEIR HR OFFICE STATING THAT YOU have the required 2,000 of CNA work experience.

WEBER STATE UNIVERSITY **Form A-2**
SCHOOL of NURSING and WSU Continuing EDUCATION
Medication Aide Certified (MAC) Program
Demographics Form

Directions: Provide the requested information and return to the Enrollment Director

Complete name _____

E-mail: _____

Street address _____

City, State, and Zip Code _____

Phone number(s) Home_____ Work _____ Cell _____

Social Security Number _____

CNA Certificate # _____
(Must provide a copy of CNA Certificate with this packet of information)

Emergency Contact Information:

Name_____

Address_____

_____

Phone Number(s) _____

NOTE: YOU WILL BE AUTHORIZED TO BEGIN THE MEDICATION AIDE PROGRAM only after receipt of your application packet. Additionally after application is processed each admitted applicant will have to complete a Drug Test (Details will be provided to those selected to start the program)

A POSITIVE DRUG SCREEN WILL RESULT IN DISMISSAL FROM THE PROGRAM

Initial that you have read this notice and accept these conditions _____(Initials)

---------- Do Not Write Below this Line - Program Use----------

Drug Screen Clear? Yes _____ No _____
If "No", explain _____
Program Response_____

Form A-3

WEBER STATE UNIVERSITY

School of Nursing & Continuing Education
Medication Aide Certificate Program
3903 University Circle
Ogden UT 84408-3903
Phone: (801)626-6753
FAX: (801)626-6397

MEMORANDUM

TO: Medication Aide Certified (MAC) Program Students
FROM: School of Nursing Enrollment Director
SUBJECT: Instructional Information

Please answer the following questions by signing your initials under your response and then sign and date the document below. Return to Enrollment Director

	YES	NO
Due to liability issues, I understand that I will not be able to begin course work until the enclosed packet of forms have been completed and returned to the Enrollment Director. Additionally I will not receive final approval to begin the program until I have successfully completed a Drug Test that will be e-mailed to me after making it through the first approval level.	( )	( )
I understand that due to the liability issue, I may not participate in hands-on clinical experiences prior to completing all theory related course work and have completed that portion of the program successfully and have been approved by the Theory Faculty to progress to the clinical portion of the program.	( )	( )
I understand that any deviation from the standards of this program is cause for counseling procedures and/or dismissal from the Program. **I also understand that if violations result in my dismissal from the Medication Aide Certified (MAC) Program, I will forfeit paid tuition and associated expenses**.	( )	( )
I agree to comply with the policies and procedures associated with the agency in which I am assigned to complete my Clinical Practicum experience. I also agree to release Weber State University from any consequences for any negligent or careless acts committed by **me** while in the clinical setting.	( )	( )

Print Name_____

Signature_____

Date_____

Form A-4

WEBER STATE UNIVERSITY
SCHOOL OF NURSING AND COLLEGE OF CONTINUING EDUCATION
MEDICATION AIDE CERTIFIED (MAC) PROGRAM

Statement on Student Policies

I, _____, have read the policies in the Medication Aide Certificate Program Handbook. I understand that I will be given the opportunity to have questions concerning said policies answered by the Enrollment Director or Faculty/Clinical Coordinator.

I understand that, as a student in this program, if I need further clarification of the policies, I am free to ask the Enrollment Director or Faculty/Clinical Coordinator throughout the course of the program.

I shall abide by the policies as a student in the program.

_____
Print Name

_____
Signature

_____
Date

Return this signed form to the Enrollment Director

Form A-5

WEBER STATE UNIVERSITY
SCHOOL OF NURSING AND COLLEGE OF CONTINUING EDUCATION
MEDICATION AIDE CERTIFIED (MAC) PROGRAM

Release and General Indemnity Agreement

PLEASE COMPLETE THIS FORM ONLY IF YOU ARE DECLINING HEALTH INSURANCE.

I, _____, a student enrolled in the Weber State University Medication Aide Certified (MAC) Program:

Check each applicable box: ☐ 1. Not to carry medical insurance

I do hereby release, indemnify and hold harmless, Weber State University, its Board of Trustees, employees and agents from any liability for personal injury, illness, accident, (including damage to other persons or property) which I may acquire as a result of being enrolled in the Weber State University Nurse Medication Aide Certified (MAC) Program.

Subscribed and sworn to before me this _____ day of _____, 20___.

Notary Public: _____

(Seal)

Residing At: _____

My Commission Expires: _____

DO NOT SIGN PRIOR TO NOTARY OR THIS FORM IS NULL AND VOID.

Print Name: _____ Signature: _____

Form A-6

WEBER STATE UNIVERSITY
SCHOOL OF NURSING AND COLLEGE OF CONTINUING EDUCATION
MEDICATION AIDE CERTIFIED (MAC) PROGRAM
Health and Accident Insurance

Weber State University does not accept responsibility for injury or illness that occurs while you are enrolled in the MEDICATION AIDE CERTIFIED (MAC) PROGRAM. You are required to carry health insurance while attending the program.

Please indicate the name of the Insurance Company, and date and sign your name:

Name of Insurance Company_____

Print Name _____ Date_____

Signature_____

If you choose not to be covered by health insurance, please complete and return the Release and General Indemnity Agreement Form, enclosed in this packet, signed and notarized.

(Form A-7)

NOTICE OF REFUND / CANCELLATION

REFUND POLICY

Once approved for the program and payment for you has been finalized to the Continuing Education Department at Weber State University there will be no refund of those fees paid to you or any agency sponsoring you.

_____ _____

Signature Date

WEBER STATE UNIVERSITY
School of Nursing and Continuing Education
Medication Aide Certified (MAC) Program
Confidentiality Statement

Purpose:

As a student in the Medication Aide Certified (MAC) Program while participating at clinical agencies, you will have access to "Confidential Information." The purpose of this agreement is to reinforce your understanding related to the significance of retaining confidential information private. This responsibility not only in effort during your work in the program but extends throughout your professional career.

Definition of "Confidential Information:"

"Confidential Information" includes patient information, employee information, financial information, or other confidential information relating to clinical agencies. You may have access to some or all this information from various sources, including but not limited to, agency computer systems, patient records, conversations, reports, case conferences, rounds, etc.

Confidential Information is valuable and sensitive, and is protected by law. As a nurse re-entry student, and after program completion, you are required to conduct yourself in strict conformance to the confidential policies of the agency and law. Your principal duties in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties may result in discipline, which might include, but is not limited to, dismissal from the Weber State University Medication Aide Certified (MAC) Program, and to legal liability.

Agreement:

As a student, I understand that I will have access to Confidential Information which may include, but is not limited to, information relating to:

1. Patients (such as records, conversations, admittance information, patient financial information, etc.).
2. Employees of the agency (such as salaries, employment records, disciplinary actions, etc.).
3. Agency information (such as financial and statistical records; strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.).
4. Third party information (such as computer programs, client and vendor proprietary information, source code, proprietary technology, etc.).

Accordingly, as a condition of my enrollment in the WSU Medication Aide Certified (MAC) Program and in consideration of my access to Confidential Information, I promise that:

1. Information is necessary for learning; but I will use Confidential Information only as needed by me to perform my legitimate duties as a nurse.
    a) I will not access Confidential Information for which I have no legitimate need to know.
    b) I will not in any way divulge, copy, release, sell, load, revise, alter, or destroy any Confidential Information except as properly authorized by my clinical faculty, Clinical Preceptor, or agency administrators, within the scope of my role as a student in the agency.
    c) I will not misuse Confidential Information or carelessly care for Confidential Information including Confidential Information discussed in formal post-clinical discussions.
2. I will safeguard and will not disclose my access code or any other authorizations I have that allows me to access Confidential Information. I accept responsibility for all activities undertaken using my access code and other authorization.
3. I will report to my Faculty/Clinical Coordinator any suspicion or knowledge that I may have that my access code, authorization, or any Confidential Information has been misused or disclosed with the agency's authorization.

4. I will report to my Faculty/Clinical Coordinator activities, by any individual or entity, that I suspect may compromise the confidentiality of Confidential Information. Reports made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the individual reporting the activities.
5. I understand that my obligations under this Agreement will continue after completion of the Weber State University Medication Aide Certified (MAC) Program and when I am no longer a student in the program.
6. I will be responsible for my misuse or wrongful disclosure of Confidential Information and for my failure to safeguard my access code or other authorization to access Confidential Information. I understand that my failure to comply with this Agreement may result in my dismissal from the Weber State University Medication Aide Certified (MAC) Program.
7. I understand that if inappropriate use of information is observed, evidence will be forwarded to management and/or law enforcement officials and that my future employment in the agency may be prohibited.
8. I understand that if I have clinical in a facility that requires additional paperwork to be signed that I will also sign their agreement for students.

_____

Print Student's Name

_____ _____

Students's Signature (please sign legibly) Date

RETURN SIGNED DOCUMENT TO MEDICATION AIDE CERTIFIED (MAC) PROGRAM ENROLLMENT DIRECTOR.

Form A-9

WEBER STATE UNIVERSITY

SCHOOL OF NURSING

MEDICATION AIDE CERTIFIED (MAC)

CPR AND AED* STATEMENT

1. **I understand that documentation of a current CPR and Artificial Electrical Defibrillator* (AED) certification must be in my file prior to beginning the Medication Aide Certified Program**

2. I understand that two year CPR cards are acceptable. I understand that if my certification expires during my clinical experience, I am responsible to provide documentation of renewed certification. If my certification expires during my clinical experiences and I have not provided documentation of renewed certification, I will not be allowed to continue in the program until such documentation is submitted to the Program Administrator.

3. I understand that my CPR must be a Health Care Provider CPR card from the American Heart Association. ,

   American Heart Association - Healthcare Provider ONLY!!!

4. I have attached **a copy of my CPR for Health Care Providers card.**

Print Name_____Date_____

Signature_____Campus_____

RETURN SIGNED DOCUMENT TO MEDICATION AIDE CERTIFIED (MAC) PROGRAM ENROLLMENT DIRECTOR.