Mid-Coast School of Technology
Adult Education
1 Main Street
Rockland, ME 04841
Tel: (207) 596-7752 ext. 3
Fax: (207) 594-7506

Certified Nursing Assistant Program

Classes meet 9 weeks on Tuesdays, Wednesdays & Thursdays.

___July 1, 2025 ____Sept 9, 2025 ___ Nov 18, 2025 ___ March 24, 2026

Course openings are limited - apply early!

Students enrolled in this program at the Mid-Coast School of Technology will complete 130+ hours of classroom, laboratory and clinical experience, which meets all requirements of the Maine State Department of Education. Upon successful completion of the course and passage of the written State Competency Exam, the student will be able to enter the healthcare field as a Certified Nursing Assistant under the direction of a licensed nurse. Certified Nursing Assistants are employed in all aspects of the healthcare field such as in long-term care, home care, hospitals, physicians' offices, clinics and laboratories.

Each applicant will be scheduled for an interview with the instructor and program director once applicant's application is received. Applicants must meet all admission criteria satisfactorily.

Classes are limited to a maximum of 10 students.

General Schedule:

Weeks 1 & 2:	Classroom hours, 8:30 A.M. to 3:00 P.M.
Weeks 3 through 9:	Classroom hours on Tuesdays, 8:30 A.M. to 3:00 P.M.
	Clinical training on Wednesdays & Thursdays, 7:00 A.M. to 3:00 P.M.

(Exact calendar will be made available upon acceptance into the program)

Tuition is $1,195 (subject to change) and an additional $21 is charged for a state background check. Payment options include funding agency sponsorship or students may elect to privately pay for the course.

C.N.A. APPLICATION

Name:_____ Email address:_____

Address:_____ Tel #1: _____

Tel #2: _____

_____ (Must provide emergency alternate #)

Town and Zip Code

Soc. Sec #_____

Date of Birth _____

1. What is the highest grade that you have completed:

   High School 9 10 11 12 or GED/HiSET completion
   College1 2 3 4

2. What was your course of study:

3. List all health-related courses that you successfully completed, i.e. (Biology, CPR, Medical Terminology).

4. Why do you want to be a C.N.A.?

5. Please list any work you may have done in the healthcare field, both paid and unpaid.

6. Are you able to commit to a 9-week daytime training schedule?

7. Where did you hear about the C.N.A. course offered at Mid-Coast School of Technology?

8. What do you feel is your greatest asset to an employer?

9. Please list your last three employers (include dates of employment, address and telephone numbers):

(1) May call_____May not call_____

(2) May call_____May not call_____

(3) May call_____ May not call_____

10. What do you see as the duties of a C.N.A.?

11. Please describe the physical and mental requirements/duties of a C.N.A.

12. Do you have any conditions that require special accommodations? Y N

If yes, please describe.

13. Have you ever been convicted of any crime under the laws of the State of Maine? Y N

14. Have you ever been charged with abuse, neglect or misappropriation of funds? Y N

15. Have you ever appeared in court, paid any fine or been put on probation? Y N

16. Have you ever been convicted of any crime under the laws of any other state? Y N

If you answered yes to question 13, 14, 15, or 16 please attach court documents pertaining to each conviction (except for minor traffic violations).

APPLICANT'S AUTHORIZATION

I hereby state that the information submitted is true to the best of my knowledge.

I hereby acknowledge that I have received the C.N.A. Program Admission Requirements form. I have read the criteria and understand that if I do not meet these requirements, I may not be allowed admission into the program.

I hereby authorize the addressed individual company or other institutions to furnish the Adult Education Program with any information that they may have on record or otherwise concerning me.

I hereby release the addressed individual company or institutions and all individuals connected herewith, including Mid-Coast School of Technology Adult Education, from any liability for any damage whatsoever in furnishing such information.

Applicant's signature_____Date_____

MID-COAST SCHOOL OF TECHNOLOGY ADULT EDUCATION
C.N.A. PROGRAM ADMISSION CRITERIA CHECKLIST

All applicants accepted into the C.N.A. program are required to submit the following criteria in a timely manner. Incomplete submissions may result in non-acceptance or removal from the program.

☐ Completed and signed application

☐ Copy of High School Diploma or GED/HiSET completion certificate

☐ 1 Letter of reference – preferably one from an employer

☐ Completed Maine Health immunization form (see last page in this application)

☐ Copy of immunization record (includes TB test done within past 6 months, annual flu vaccine & 2 COVID vaccines, all other immunizations must be up to date or boosters administered)

☐ Copy of Driver's License or State ID

SBI (State background check) that shows no history of theft, misappropriation of funds, abuse, or neglect in a health care setting; nor a prior criminal conviction within the last 10 years for which incarceration of 3 or more years was imposed, or 3 years or less was imposed for conviction of sexual misconduct, abuse, neglect, or exploitation in settings other than health care.

Participants in the course are expected to exhibit the following during the course and on the job:
• Good Personal Hygiene • Dependable, reliable work habits • Professional interpersonal behavior

Done on location:
Interview with Instructor and Program Director
Payment and online processing of State Background check (see permission slip that follows)

Entrance Exam – CASAS (score in Reading: ≥ 239)

<u>How to Complete the Required Background Check</u>

To meet our program requirements, we will need to request a Maine State Bureau of Identification (SBI) check which costs $21.00 (when done through MCST). Please note that the agencies funding you will pay for this. The request for the background check is accomplished through our Business Manager's office. Please fill out and turn in the attached "permission for background check" paperwork. **It is necessary to request additional SBI searches for each formal name used as an adult, including maiden name.**

Failure to complete background checks in a timely manner will result in non-acceptance to the program or dismissal if you have been provisionally accepted without this documentation.

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MID-COAST SCHOOL OF TECHNOLOGY ADULT EDUCATION

Bobby Deetjen
Director, MCST

Heidi Nolan
Director, Adult Education

Permission for Background Check

To ensure the safety and protection of patients and residents that will be cared for in the hospital and nursing facility settings, DHHS mandates that a background check be performed on all students entering the CNA programs. Please fill out the required sections below and sign that you are giving Mid-Coast School of Technology permission to perform a background check.

Your complete name: ____

All previous last names you have had: ____

Date of birth: ___________________________
I give MCST my permission to perform a background check.

Your signature:____Date:_______________

Release of Social Security Numbers and Exchange of Information

Adult Education in Maine is required by Title II of the Workforce Innovation and Opportunity Act to report how many adult learners:

- Are employed after attending adult education

and/or

- Have entered college or a training program after attending adult education

Federal funds are used to pay for some of our classes including reading, writing, math, high school equivalency and high school diploma courses. Gathering employment and post-secondary education information is needed to receive the funding that pays for this part of adult education.

To get this information, this adult education program will use your Social Security Number to match adult education enrollment records with employment and post-secondary records with the agencies listed below.

- The Maine Department of Labor—to report how many adults from Maine Adult Education Programs are employed. The data match **does not identify you by name** or where you work.
- The National Student Clearinghouse—to report how many adults from Maine Adult Education Programs are enrolled in post-secondary institutions.

We are asking you to sign this form giving us permission to use your Social Security Number for **a data match** in order to obtain the information we need for federal reporting.

The information obtained by the Department of Education will be used for the sole purpose of data match reporting **and will not be shared with other individuals or agencies without your written permission**. All data used to conduct the data match will be purged from the Department of Labor system after the report is complete.

I give permission to use my Social Security Number:

- DATE _____
- Signature _____
- Print Name _____

Appendix A

IMMUNIZATION VERIFICATION CHECKLIST

For individuals who are not employed by MaineHealth

Required Immunizations
Varicella (chickenpox) • Two vaccine doses at least 4 weeks apart –OR– • Immunity by positive blood titer –OR– • Provider documentation of month and year of past illness
Measles, Mumps, Rubella (MMR) • Two MMR vaccine doses at least 4 weeks apart –OR– • Two measles, two mumps, and one rubella vaccine dose –OR– • Immunity by positive blood titer for measles, mumps, and rubella
Influenza (annual requirement) • One dose of seasonal vaccine annually
SARS-CoV-2 (COVID-19) • Two doses of Moderna, Pfizer, or Novavax vaccine –OR– • One dose of Johnson and Johnson vaccine • Boosters are not required but are strongly recommended and documentation requested • There is no acceptable titer and prior history of disease is not accepted as proof of immunity
Recommended Immunizations
Tdap (tetanus, diphtheria, and pertussis) or **Td** (tetanus, diphtheria) • One dose of vaccine < 10 years ago
Hepatitis B • Two or three vaccine doses depending on brand –OR– • Immunity by positive blood titer
Recommended Tuberculosis Screening
• Two-step TB Skin Test (TST): 2 TB skin tests placed > 1 week apart but within 1 year, with at least 1 test < 12 months ago – OR– • An Interferon-Gamma Release Assay (IGRA) blood test for TB infection in the last 12 months • Positive results require a chest X-ray within the last 2 years demonstrating no active disease • If chest x-ray is positive, documentation of further evaluation is required

- Credentials of provider submitting records should be MD, DO, NP, PA, RN, or other healthcare providers authorized to administer vaccines, such as RPh or PharmD
- Naturopathic providers (ND) cannot submit exemptions
- Providers cannot submit records on their own behalf

https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm

Appendix B

IMMUNIZATION VERIFICATION CHECKLIST

For individuals who are not employed by MaineHealth

Licensed MD, DO, NP, PA, RN, or other healthcare providers authorized to administer vaccines, such as RPh or PharmD, should complete and sign this form.
Workers should not complete or sign this form themselves.

First name: Last name: Birth date:

Complete applicable boxes only. If a box does not apply, please leave blank.

Immunization	**1st dose (mm/dd/yy)**	**2nd dose (mm/dd/yy)**	**Antibody titer**
Varicella			☐ Immune ☐ Not immune
MMR			☐ Immune ☐ Not immune
Measles			☐ Immune ☐ Not immune
Mumps			☐ Immune ☐ Not immune
Rubella			☐ Immune ☐ Not immune

If history of **varicella**, documentation of month and year of past illness (mm/yy): Most recent dose

of **influenza** vaccine (mm/dd/yy):

SARS-CoV-2**:**

Complete applicable boxes only. If a box does not apply, please leave blank.

Vaccine name	**1st dose (mm/dd/yy)**	**2nd dose (mm/dd/yy)**	**Most recent booster (mm/dd/yy)**

Last dose of **Tdap or Td** *(mm/dd/yy)*: Vaccine type: Tdap ☐ Td ☐

Hepatitis B vaccine:

Complete applicable boxes only. If a box does not apply, please leave blank.

Vaccine name	**1st dose** (mm/dd/yy)	**2nd dose** (mm/dd/yy)	**3rd dose** (mm/dd/yy)	**Antibody titer**
				☐ Immune ☐ Not immune

Tuberculosis screening:

Two-step TB skin test: *2 TB skin tests placed > 1 week apart but within 1 year, with at least 1 test < 12 months ago*

-**Step 1** test date (mm/dd/yy): **Result** (positive or negative):

-**Step 2** test date (mm/dd/yy): **Result** (positive or negative):

-OR-

IGRA blood test date (mm/dd/yy): **Result** (positive or negative):

Date and results of **chest X-ray**, if applicable:

Please complete vaccine exemption or vaccine deferral form if needed.

_____ _____

*Signature of **medical provider*** *Printed name of **medical provider***

Credentials of medical provider: ☐ MD ☐ DO ☐ NP ☐ PA ☐ RN ☐ RPh or PharmD

Office phone number: