CAROLINAS HOSPITAL SYSTEM
Marion
2829 E. Highway 76
Mullins, SC 29574
www.carolinashospitalmarion.com

Application for Nurse Aide Training Program
Mullins Nursing Center
518 S. Main Street
Mullins, SC 29574

Section I
Personal Information

Name: _____
Address: _____
_____
_____
Telephone Number: _____
☐ Home ☐ Cell
E-mail Address: _____

Section II
Education

High School Attended: _____
Date of Graduation: _____
GED: _____
Date Obtained: _____
College(s) Attended: _____
Dates Attended:_____
Graduation Date: _____
Degree/Certification Earned: _____

Section III
Employment (add additional page if necessary)

Employer: _____
Address: _____
Dates of Employment: _____ to _____
Name during employment: _____
Position Held: _____
Supervisor: _____
Reason for Leaving: _____

Employer: _____
Address: _____
Dates of Employment: _____ to _____
Name during employment: _____
Position Held: _____
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Section IV
Certifications

BLS/CPR	☐ Yes	☐ No
Crisis Prevention Intervention (CPI)	☐ Yes	☐ No
SC Works WIOA Program	☐ Yes	☐ No
Work Keys	☐ Yes	☐ No
Applied Math Score _____		
Graphic Literacy Score _____		
Workplace Documents Score _____		
Workplace Observation Score _____		
Other: Provide name of certification(s)	☐ Yes	☐ No

_____

_____

Section V
References (no relatives)

1. Name: _____
   Relationship: _____
   Telephone Number: _____
   E-mail Address: _____

2. Name: _____
   Relationship: _____
   Telephone Number: _____
   E-mail Address: _____

3. Name: _____
   Relationship: _____
   Telephone Number: _____
   E-mail Address: _____

Section VI
Referral

How did you hear about our program?

Section VII
Prescreening Questions

1. Are you now or have you ever been excluded, suspended, or debarred from participation in any federally funded benefit program (e.g. Medicare/Medicaid)?
   ☐ Yes ☐ No

2. Are you now or have you ever been sanctioned or reprimanded by a state or federal licensing or certification agency/authority?
   ☐ Yes ☐ No

3. Are you registered, or ordered to be registered, on the National Sex Offender Public Website or other governmental sex offender/predator registry?
   ☐ Yes ☐ No

4. Are your professional license, registration or certification currently under investigation?
   ☐ Yes ☐ No

5. Do you have any criminal convictions or any pending criminal charges?
   ☐ Yes ☐ No

6. Do you have any relatives currently employed at this facility?
   ☐ Yes ☐ No

7. Have you ever been convicted, or pleaded “no contest” to a felony and/or misdemeanor?
   ☐ Yes ☐ No

8. Have you ever had a professional license, registration or certification reprimanded, sanctioned, suspended, revoked, placed on probation, limited or voluntarily surrendered/relinquished it?
   ☐ Yes ☐ No

9. Have you ever worked at this facility or any other CHS affiliated facility?
   ☐ Yes ☐ No

10. If you are offered admission into the program, will you be able to provide documentation demonstrating that you are legally entitled to work in the United States?
    ☐ Yes ☐ No

Section VIII
Short Answer Essays (Limit 250 words per essay)

Why do want to attend the Carolinas Hospital System – Marion Nurse Aide Training Program?

Why should you be selected to attend the Nurse Aide Training Program?

What are you career goals?

Signature: _____
Date: _____

Section IX
Commitment Agreement

I understand that by taking the Nurse Aide Training Program Course offered by Carolinas Hospital System – Marion that I am obligated to work for the company for a period of 1 year. I understand that I could be employed at Carolinas Hospital System – Marion (Main Campus), Mullins Nursing Center, Marion Physician Services, or Carolinas Hospital System (Florence campus).

I understand that I am not guaranteed full-time employment unless a position is available and offered to me. I understand that I may be employed part-time or PRN (as needed).

I understand that I am not guaranteed a certain shift (first, second, third, weekends, etc.) and I will have to work the hours and shifts that are available and offered to me.

I understand that I am not guaranteed a position in a certain facility and may have to work at a facility within the system that is not of my choice.

I understand that I must attend all class time and clinical time or I will be dismissed from the program.

I understand that I am responsible for my own learning and will have to spend time outside of class time studying and practicing skills.

I understand that I must abide by all the rules, regulations, and policies and procedures of the program and of the facility (including the dress code policy) and if I do not I may be dismissed from the program.

I verify that the undersigned has explained this form to me and answered any questions that I may have concerning the above statements.

Student Signature: _____ Date: _____
Instructor/Admin signature: _____ Date:_____

Section X
Student Work Preferences

Student Name: _____
Date: _____

Preferred Facility:

- ☐ Carolinas Hospital System – Marion (Main Campus)
- ☐ Mullins Nursing Facility
- ☐ Marion Physician Services
- ☐ Carolinas Hospital System (Florence Campus)

Preferred Shift:

- ☐ 7a-3p
- ☐ 3p-11p
- ☐ 11p-7a
- ☐ 7a-7p
- ☐ 7p-7a
- ☐ Weekends

Preferred Status:

- ☐ Full Time – 40 hours/week
- ☐ Full Time – 36 hours/week
- ☐ Full Time – 32 hours/week
- ☐ Part Time – 24 hours/week
- ☐ PRN – As Needed