



VOCATIONAL NURSING PROGRAM

Class of 2026 - 2027

Schedule of Classes and Program Cost

The Vocational Nursing Program is a 1554-hour / 52-week program. The school believes that nursing is a scientific discipline with a distinct body of knowledge, manifested by the art of caring. The school facilitates learning through a variety of approaches such as developing material, selecting learning strategies and resources, implementing teaching strategies, stimulating discussions, participating in dialogue, monitoring/evaluating student progress, adjusting curriculum to meet student needs, and reporting progress.

Below is the schedule of classes and the fees for the Vocational Nursing Program.

Schedule of Classes		
Theory/Classroom/Skill Lab	Monday through Friday	8:00 AM - 2:30 PM (Varies)
Clinical Rotation	Monday through Friday	7:00 AM - 3:30 PM

Program Cost		
Tuition		\$37,775
ATI and Swift River Platform		\$2250
Registration Fee		\$100
STRF - Nonrefundable		\$0
Uniforms (4 Sets of Uniforms with School Logo)		\$350
Textbooks, Materials and Misc*		\$ 1000
	Total	\$41,475

Textbooks:

Anatomy and Physiology for Health Professional, 4th Ed.

Foundations and Adult Health Nursing, 9th Ed by Cooper and Gosnell

Saunders Comprehensive Review Book

Nursing Drug Handbook (Current Year)

***Miscellaneous:** Littmann Stethoscope and Background Check

Vocational Nurse Program Application Checklist

Academic Requirement

- Form A: Student Registration _____
- High School Diploma, GED or Equivalency _____
- Test of Essential Academic Skills (ATI TEAS) Exam at Proficient Level _____
- Submit an Essay on “Why Do I Want to Become a Nurse?” _____
- Ability to Communicate Fluently in both Written and Spoken English* _____

Health Assessment

- Form B: Health History _____
- Form C: Physical Examination and TB Clearance _____
- Form D: Immunization/Titer Results _____
- Annual Flu/ Covid Vaccine _____

Background Check

- Complete Live Scan/ Bring Completed Copy _____
- Complete Drug Screening _____
- BLS/ CPR Certificate _____

Note:

Submission of an application does not guarantee acceptance.

For transfer credit, please contact the student coordinator for Credit Granting Policy.

*For those whose first language is other than English, we encourage students to take ESL classes offered at Community Colleges.



2345 E 8th Street, Suite 113 • National City, CA 91950
Office: (619) 488-3460 • Fax: (619) 488-3479

PROGRAM: Vocational Nurse Nurse Assistant

FORM A: STUDENT REGISTRATION

(This section to be completed by the student. Please use ink and print clearly)

Name: _____ DOB: _____

Address: _____

Phone Number: _____ Email Address: _____

Social Security: _____

Emergency Contact: _____ Contact Number: _____

For statistical purposes only, identify yourself in one of the following groups:

- Hispanic, Mexican Asian/Pacific Islander Other, specify: _____
 White American Indian
 Black Filipino

Are you able to perform the essential job functions of the profession/career you are applying with or without reasonable accommodations? Yes No

Do you primarily speak a language other than English? Yes No

What is that language? _____

How well do you speak that language? Very well Well Not very well

Do you require English language assistance? Yes No

How well do you speak English? Very well Well Not very well Not at all

PLEASE READ AND SIGN:

The information submitted in this application packet is complete and accurate. I understand that falsification of any information on this application may be cause for non-selection or dismissal from the program.

Student Signature

Date



FORM B: HEALTH HISTORY

(This section to be completed by the student. Please use ink and print clearly)

Name: _____ DOB: _____

Allergies (Drugs/Food): _____

Current Medications: _____

Past Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer; Type | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy (seizure disorder) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Bleeding Problem | | |
| <input type="checkbox"/> Other: | | |

Past Surgical History

Type of surgery: _____

When: _____

System Review

In the past month, have you had any of the following problems?

General

- Weight loss
- Weight gain
- Fatigue or weakness
- Fever, chills, or night sweats

Muscle/Joints/Bones

- Muscle weakness
- Numbness
- Joint Pain
- Joint swelling

Ears

- Loss of hearing

Eyes

- Loss of vision

Throat

- Frequent sore throats

Heart and Lungs

- Chest pain
- Palpitations

Nervous System

- Headaches
- Dizziness
- Fainting or loss of consciousness

Stomach and Intestines

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Constipation
- Persistent diarrhea

Skin

- Redness:
- Rash

Blood

- Anemia
- Clots

Kidney/Urine/Bladder

- Frequent or painful urination
- Blood in urine

Psychiatric

- Anxiety
- Depression
- Excessive worries
- Insomnia
- Poor appetite
- Thoughts of suicide/attempts
- Irritability
- Poor concentration
- Mood swings

Other symptoms: _____

Immunizations:

MMR _____

Hepatitis B _____

Tetanus _____

Varicella _____

TB Screening _____

Influenza _____

Student Signature: _____ Date: _____ Provider Initials: _____



FORM C: PHYSICAL EXAMINATION
(This section to be completed by the DO, MD, NP or PA only)

Name: _____ DOB: _____ Social Security: _____
 Gender: Male Female Height: _____ Weight: _____
 Vital Signs: _____ Pulse: _____ RR: _____ Temp: _____
 Vision OS: _____ OD: _____ Hearing R: _____ L: _____

System	Function WNL		
	Yes	No	Comment
General			
HEENT			
CV			
Pulmonary			
GI			
GU			
Neurological			
Integument			
Musculoskeletal			
Immune system			
Endocrine			
Mental Health			

Function	Ability to Perform		
	Yes	No	Comment
Able to work standing, sitting, bending, and lifting			
Able to use all physical senses			
Able to perform fine motor skills			
Able to coordinate physical and mental activities to perform tasks or skills safely			
Does not have health conditions that create a hazard to self or others			
Are there recommendations for continued medical care			

Healthcare Provider Name: (Printed/Stamped): _____
 Signature: _____ Date: _____



FORM C: PHYSICAL EXAMINATION (CONT)

(This section to be completed by the DO, MD, NP or PA only)

Tuberculosis Clearance

Student must submit TB clearance form only 1 of the 3 options described below:

1. **TB PPD Skin Test.** Note: A 2-Step TB PPD (2nd PPD must be administered at least 10 days from the 1st PPD being administered) is required if the student has not had a PPD in more than 1 year, or 365 days.

Having a history of BCG vaccine alone is not acceptable as a positive PPD history unless a skin test has been given and the result was 10 mm or greater.

2. **IGRA (e.g., QuantiFERON or T-spot).** Lab report must not be more than 6 months from the first day of matriculation. In addition, student must submit a completed TB Symptoms Checklist.

IGRA Date: _____

(Note: This test is valid for 4 years at The Nurse Academy).

3. **Chest X-Ray/Radiology Report.** If student has a positive PPD history, a current X-Ray report must not be more than 6 months from the first day of matriculation is required. In addition, student must submit a completed TB Symptoms Checklist.

Chest X-Ray date: _____

Two Step Tuberculosis (TB Screening)

TB Skin Test: 5 tuberculin units (TU)/0.1 mL administered intradermally.

Test #1		
Date: _____	Site: _____	Signature: _____
Reading: _____	mm induration: _____	mm erythema: _____
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Signature: _____	

Test #2		
Date: _____	Site: _____	Signature: _____
Reading: _____	mm induration: _____	mm erythema: _____
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Signature: _____	

Healthcare Provider Name: (Printed/Stamped): _____

Signature: _____ Date: _____



FORM D: IMMUNIZATION/TITER RESULTS

(This section to be completed by the DO, MD, NP or PA only)

Name: _____ DOB: _____

Vaccine	Titer	Series #1	Series #2	Series #3
Hepatitis B*	Titer: _____ Date: _____ B Surf Ab, Quantitative QN	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	Date: _____ (6 Months after #1)
Measles (Rubeola)**	Titer: _____ Date: _____ Rubeola AB, IgG, EIA	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Mumps**	Titer: _____ Date: _____ Mumps AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Rubella**	Titer: _____ Date: _____ Rubella AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Varicella**	Titer: _____ Date: _____ Varicella AB IgG	Date: _____ (Day 0)	Date: _____ (30 Days after #1)	
Tetanus Diphtheria Acellular Pertussis (Tdap)		Date: _____ Note: Td/Dtap will not be accepted.		

*Note: If a student has received 2 complete Hepatitis B series (one series consists of 3 vaccines) and the titer still shows no immunity, then student must provide proof of 2 complete vaccination series before the student can be declared a Hepatitis B non-converter. Once declared a non-converter, the student will not be required to receive any more Hepatitis B vaccines.

**Note: If titer results for Measles, Mumps and Rubella (MMR), and Varicella are negative or inconclusive/equivocal and there is no documentation showing completion of MMR and Varicella vaccine series (2 vaccines), then student must start the vaccination series which is 2 immunizations 30 days apart.

Healthcare Provider Name: (Printed/Stamped): _____

Signature: _____ Date: _____



TB SYMPTOMS CHECKLIST

(This form only applies to those required to have a Chest X-Ray or have had an IGRA (QuantiFERON test))

Name: _____ DOB: _____

Have you ever had a BCG vaccination? Yes No
(If yes, it is preferred that you obtain an IGRA (e.g., QuantiFERON or T-spot test))

Date of last PPD: _____ Results: _____ mm

Date of IGRA (e.g., QuantiFERON or T-spot test): _____ Results: _____

Date of last Chest X-Ray: _____ Results: Positive TB Negative TB

Have you ever been told you have active tuberculosis? Yes No

Have you ever taken Isoniazid (INH) or Rifampin (RIF)? Yes No

Date and duration of medication regimen: _____ (months)

During the past year, have you noticed:

Unexplained weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Decrease in your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough not associated with cold or flu?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Increase in amount of sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in color of sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood streaked sputum?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night sweats?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained low-grade fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual tiredness or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enlarged lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had contact with a family member or partner who has been diagnosed with tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or a member of your family been exposed to someone who is immune compromised?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explain any "yes" answers: _____

List any on-going medical problems: _____

Student Signature

Date