

FOUR COUNTY AREA VOCATIONAL COOPERATIVE

APPLICATION FOR DIRECT HEALTH CARE

DUE 2/19/10 TO FCAVC ADMINISTRATIVE OFFICE

NAME: _____
(LAST) (FIRST) (M. INITIAL) (BIRTHDATE)

HOME ADDRESS: _____

CITY: _____ STATE: IN ZIP: _____

TELEPHONE: _____ SOC. SEC. #: _____

NAME OF HOME SCHOOL: _____ STN#: _____

GRADE LEVEL for 10-11 SCHOOL YEAR: 11 _____ 12 _____ (Consult Guidance Counselor if unknown)

PARENT(S)/GUARDIAN(S) NAME _____

EMAIL ADDRESS (FOR INFORMATIONAL USE ONLY): _____

I understand and agree to fulfill the following conditions of my enrollment in the Direct Health Care program, administered by the Four County Area Vocational Cooperative:

CRITERIA FOR DIRECT HEALTH CARE APPLICANTS

1. Student must be entering his/her junior or senior year of high school.
2. Student must have an interest in nursing.
3. Parent or guardian permission is necessary for admittance to the class.
4. If your home school does not provide transportation, you must have reliable transportation.
5. Student must follow state guidelines including a required amount of clinical hours. Meeting the hour requirements may involve attending on scheduled days off.
6. Student must follow a dress code.
7. Student must call instructor if unable to attend class.
8. Student must demonstrate a professional attitude.
9. Strict patient confidentiality is important. Failure to comply will result in removal from the program.
10. Student will do all clinical rotation in the long term care facility or nursing home with vocational instructor.
11. Student must demonstrate excellent attendance; poor attendance will result in your inability to earn your certification.

I have read and agree to the above conditions of my enrollment:

Parent or Guardian Date

Student Date

Required for Enrollment: _____
Guidance Counselor Signature

Special Notes: _____