Quality CNA Training LLC - Wisconsin
Green Bay ● La Crosse ● Monona ● Manitowoc ● Waupaca ● Kaukauna ● New Glarus ● West Salem
Coming Soon
● Appleton ● Fond du Lac ● Madison

For More Information call
1-715-902-1035 or visit
https://QualityCNATraining.com/

Follow us on Facebook by searching….
https://www.facebook.com/QualityCNATraining/

Certified Nursing Assistant: A Career that can change your life!

Imagine a job that rewards you for caring about others…that is exciting and challenging…a job where you make a difference. Whether you're just starting your career or ready for a change, now it the time to consider becoming a Certified Nursing Assistant.

Quality CNA Training is a provider of Nurse Assistant Training that FULLY prepares individuals for work in the nursing field. Student learn in a hands-on environment under the eyes of caring and professional nurses, supported by a curriculum that exceeds state standards.

Our program fee is $795.00 and includes a total of 120 hours of fully supervised classroom, lab and clinical training, all participant materials, background checks plus an additional 20+ hours of enhancement hours. The enhancement hours include a 2 yr certification in AHA BLS CPR/AED and AHA First Aid plus Blood Pressure and Bloodborne Pathogens training to provide you with a competitive advantage when searching for employment. In addition, one-on-one tutoring is available when needed. Students are also provided with additional information in Life Skills including resume' and cover letter writing along with interviewing tips and tidbits.

Your State Exam is prescheduled for you to ensure a testing date immediately after graduation. This will help ensure your ability to obtain gainful employment as soon as possible. This also provides our students with the opportunity to test in a classroom you are familiar and with classmates with whom you are familiar. This helps relieve a lot of the additional stress behind testing.

Enclosed are copies of the Nursing Assistant Training Application, program information and policies, background information disclosure release form, health forms, flu shot *(only needed from Oct – March)* and TB Test forms.

We are looking forward to helping you build a successful career in healthcare!

Tanya Christianson

Tanya Christianson, Student Services
Cell: (715) 902-1035
Fax: 920-446-2334
Tanya@QualityCNATraining.com

Application Process and Procedures

Course Forms:

I understand that IN ORDER TO REGISTER for a class I need to return the following items with my completed application.

_____ The completed application. *(Pages 1-3, Background Check Forms, Self-Assessment Physical Form & Demographics Form)*

_____ A copy of your driver's license and a "SIGNED" copy of your social security card *(please put both on one page)*

_____ If an outside source is covering all or a portion of the cost of the training *(UMOS, DWD, DVR, NEW CAP, W2-WIA, CAP Services, St Vincent De Paul, etc.)* a signed voucher must be included with the application. Contact information is below

_____ Payment in the form of a Credit Card, Debit Card or Money Order *(NO PERSONAL CHECKS or CASH Accepted)*

How to register: 1) Fax forms to: 920-446-2334

2) Scan and email completed forms to: Tanya@QualityCNATraining.com or

3) Mail above forms to our main office: Quality CNA Training, 9591 Ash Lane, Fremont, WI 54940

For any questions or concerns please contact Tanya via email at **Tanya@QualityCNATraining.com** or **715-902-1035.**.

I understand that ONCE I AM ACCEPTED into a class I need to return the following items on or before the first day of class.

_____ 2-Step TB test, Chest X-ray or Quantiferon Gold Blood Test _____ Flu Shot (Required between Oct – March)

Course Uniforms:

_____ I understand that I will need to wear a LIGHT BLUE scrub top and BLACK scrub bottoms to ALL class activities including CPR/First Aid, Classroom, Lab, Clinical and for Graduation Day.

Media / Photo Information Release

Periodically throughout the training program the instructors will take pictures of the students practicing skills. These photos are then posted on our Facebook page and website for the students and our members to see. Students are then able to tag themselves or share the photos on their personal pages for their friends and families. Occasionally we use these photos for marketing purposes. Group photo's are typically taken and shared on the last day of class.

Disclaimer: I give Quality CNA Training LLC, its designees, agents and assigns, unlimited permission to use, publish and republish in any form or media, information about me and reproductions of my likeness (photographic or otherwise) and my voice, with or without identification of me by name.

☐ I agree to these terms and conditions.

☐ I chose not to have my photos posted but understand that it is then my responsibility to ensure that I am not included in any photos taken during the class or at graduation.

SIGNATURE:_____AGE (if Minor):_____

PRINT NAME:_____ DATE:_____

Consent of parent or legal guardian if above individual is a minor. I consent and agree, individually and as a parent or legal guardian of the minor named above, to the foregoing terms and provisions.

SIGNATURE:_____DATE:_____

PRINT NAME:_____

QUALITY CNA TRAINING LLC NURSING ASSISTANT TRAINING APPLICATION

The purpose of the *Quality CNA Training LLC* training course is to provide the information and skills that will enable nurse assistants to provide quality care for residents in nursing homes, as well as supplemental information and skills that will enable them to provide quality health care for clients at home and patients in hospitals. The program is designed with input from educators, caregivers, and long-term industry representatives from across the United States. *The American Red Cross Nurse Assistant Training* materials are used during class and approved by the State of WI Department of Health Services and provides students with the required job skills to become qualified CNA's.

Quality CNA Training LLC is accepting applications for upcoming Nurse Assistant Training classes.
Classes are offered at the following locations.

Green Bay ● Kaukauna ● La Crosse ● Madison/Monona ● Manitowoc ● New Glarus ● Waupaca ● West Salem

Registration Guidelines: Students **MUST attend ALL classroom, lab and clinical hours** as mandated by the State of WI. Enrollment is limited! Acceptance is based on first come, first served, with completion of a student application packet, copies of DL & SS Card and the **course payment of $795.** If you are receiving a scholarship or being sponsored by an outside organization or business, verification of sponsorship must be submitted along with the application. **A student is not considered registered until the required paperwork has been received**.

Refunds: If a student decides not to take a class after payment has been received but before the first day of class, student will receive a refund of what has been paid less the $250.00 enrollment fee. Occasionally there are significant life events – health issue, family emergency, etc., that make them unable to attend or complete a course. Students must provide documentation to be eligible for a waiver of the fees to be transferred into a future class. Students who have started the course are not eligible for a refund. Students do not receive a refund if they are dismissed from the course for cause. Students will not receive a refund if they fail the course.

Absentee Hours: Students who miss classroom hours need to utilize the pre-scheduled make-up day and will be required to pay an additional $35.00 per hour that needs to be made-up. Students who are late or miss clinical time will be dropped from the program without refund.

State Exam: The evaluation fee is not part of the training program. **The State Exam Testing fee is $125. Payments must be entered in the online portal upon graduation** in order to be included with the class for "in-facility" testing at the Quality CNA Training site.. The Quality CNA Training center is an approved "in-facility" testing site. If either the written or skills portion of the initial evaluation is failed, subsequent evaluation(s) must be scheduled at a regional testing site at the student's expense. Those successfully completing the Nurse Assistant Training program that DO NOT wish to participate in "in-facility" testing will be scheduled at a Regional Testing location of their choice.

Acceptance into this course does not guarantee receiving a certificate of completion, nor does it guarantee passing the state test for licensure if the course certification is received. For questions regarding the CNA program contact Tanya Christianson, Student Services at (715) 902-1035 or by email at Tanya@QualityCNATraining.com.

(Signature below indicates you have read and understand the Quality CNA Training payment information listed above.)

SIGNATURE:_____AGE (if Minor):_____

PRINT NAME:_____ DATE:_____

Consent of parent or legal guardian if above individual is a minor. I consent and agree, individually and as a parent or legal guardian of the minor named above, to the foregoing terms and provisions.

SIGNATURE:_____DATE:_____

PRINT NAME:_____

QUALITY CNA TRAINING LLC NURSE ASSISTANT TRAINING APPLICATION

Class Location: ___ Appleton (coming soon) ___ Fond du Lac (coming soon) ___ Green Bay ___ Kaukauna ___ La Crosse ____ Madison (coming soon) ___ Manitowoc ___ Monona ___ New Glarus ___ West Salem ___ Waupaca

Class Start Day: _____ ***Payment Attached:*** Money Order ____ Credit Card ____ Sponsor ___

PLEASE PRINT LEGIBLY

First Name_____ Last Name _____

GENERAL INFORMATION:

Address _____ City_____State _____ Zip _____

County _____ Cell Phone: (_____) _____ Alternate Number : (_____) _____

Personal Email Address_____

(**REQUIRED:** Please do NOT use school or work email – NOTE: Class communication is do through emails and text)

How did you hear about our program? Friend/Relative Previous Graduate Online Ad/Newspaper Community Agency

We provide a referral bonus…Please list name of the individual or organization: :_____

EMERGENCY CONTACT: Name _____ Relationship _____

Emergency Telephone: (_____) _____ Alternate Emergency Number: (_____) _____

Please Note Any Special Considerations That Might Affect Your Ability To Participate In this Program: _____

_____

Have you worked as a Nurse Assistant/Home Health Aide before? YES NO Were you previously certified? YES NO

BACKGROUND INFORMATION DISCLOSURE RELEASE

I give to Quality CNA Training LLC, its representatives and assigns, permission to receive, read, copy, and duplicate, any criminal justice summary data sheets forwarded from the state of Wisconsin Department of Justice (DOJ) as a result of submission of Wisconsin Criminal History Request Form (DJ-LE-250A), and any responses received from the Department of Regulation and Licensing (DRL) and the Department of Health and Family Services (DHFS) for purposes of fulfilling provisions of sections 48.685 and 50.065 of the Wisconsin Statutes.

I understand that copies of the information listed above and received by Quality CNA Training LLC will be presented/delivered to the Clinical Training Facility prior to entry into the clinical portion of the *Nurse Assistant Training* program.

I understand that based on the results of this information received by Quality CNA Training LLC and presented/delivered to the local clinical sites prior to the clinical portion of the *Nurse Assistant Training* course, I may be denied entry into the clinical portion of the Nurse Assistant Training program.

I understand that denial of entry into the clinical portion of the *Nurse Assistant Training* course does not entitle me to reimbursement of any of the course fee paid or invoiced to date.

(Please print legibly)

_____

Full Name – First Middle Last Social Security Number

_____

Address City State Zip Code

_____

Telephone Number Date of Birth

Read & Initial	***Nurses Assistant Training Program Information and Policies***
	Attendance and punctuality are required for all class and clinical sessions. Refunds will not be given for missing class or clinical time. See course and student information from registration packet for the full policy.
	LIGHT BLUE Scrub Top and a BLACK Scrub Pants are required to be worn to each course sessions/activity. Footwear must be low heeled, non-skid shoes with closed toes and heels, ***tennis shoes are acceptable***. Socks must also be worn. Watch with second hand is optional. Students NOT wearing proper attire will be asked to go home and change. Missed time will fall under the attendance policy listed below.
	ATTENDANCE: Students are responsible for participating in a scheduled make-up day for any missed classroom time as indicated in the course schedule. **Absentee students utilizing the make-up day will be required to pay an additional $35.00 per hour. No PERSONAL checks accepted & all payments must be made in advance. Zero hours may be missed from the clinical time. You WILL automatically fail if clinical time is missed.**
	Personal hygiene is important. Daily bathing and use of deodorant is required. Aftershave, cologne or perfume use is not appropriate for classrooms and clinical. Outside of wedding, engagement bands and small post earrings in earlobes, jewelry is not permitted. Facial piercing must be removed or covered. Fingernails should be short and clean. Absolutely NO fake or acrylic nails will be permitted. Hair should be clean and neat and should be tied back and away from the face.
	Cell phones MUST be turned-off or muted during classroom time and are not allowed during clinical. Students found text messaging during classroom and/or clinical time will be dismissed from the class without refund. Students are allowed to use cell phones on breaks but not within the classroom or the clinical setting.
	Professional, respectful, and safe behaviors are expected at all times, both in the classroom and clinical. Verbal or physical abuse of students, residents, instructors or clinical staff will lead to immediate dismissal from class. Class disruptions, theft or damage to property will not be tolerated and will lead to dismissal from the class without refund and other appropriate actions will be taken when necessary.
	Students receiving two memorandums from the instructor with regards to action or lack of action within the training program WILL be dismissed from the program. Students may be dismissed at any time for inappropriate behavior. No refunds will be provided.
	A student must email Tanya, Student Registration at Tanya@QualityCNATraining.com to officially cancel from the course. "No Shows" are not considered officially cancelled. If cancellation or dismissal occurs after class has started, no refund will be given and the sponsoring agency will be invoiced for the full course fee.
	Equipment and supplies are the property of Quality CNA Training LLC and/or the clinical site and should not be damaged or altered or a student may be required to pay for the cost of the item(s). All supplies and equipment should not leave the classroom or clinical site.
	Payment of the course fee and attendance does not entitle the student to course certificate, licensure or employment. Completion certificates must be earned by attending and participating, demonstrating the knowledge, attitudes and skills which meet the course exit requirements. Students are expected to complete their homework, skills and assignments, and have a test score of at least 80% to be successful in the course.
	Smoking/Vaping is only allowed in designated areas during break periods only. The consumption of alcohol is prohibited before and during classroom periods.
	You are expected to arrive for each course session at least 5 minutes prior to the start of class so that you are IN your seat promptly on class start time. You must stay until dismissed and attend all sessions.
	Nurse Aide Training Manuals ($60) and Name Tags ($10) are to be returned on the last day of class so future students may use them. Any damaged or lost items are to be replaced at the student's expense.
	Program questions, concerns and complaints should be emailed to Paulene Kipke, Nurse Aide Training Manager at Paulene@QualityCNATraining.com or 715-281-5064 between 8 am - 4:30 pm, Monday - Friday. NOTE: Paulene will conduct a follow-up within two business days to address any situation.

I have read the N.A.T. Training Program Information and Policies outline and agree to comply with the guidelines.

Student Signature	

Quality CNA Training LLC Student Demographics Form

Submission of the Demographics Form is OPTIONAL, HOWEVER we use this form to help you find potential funding resources. We have been able to happily help over 70% of our students find grants and scholarships to help offset the cost of the training.

First Name_____ Last Name _____

Cell Phone: (_____) _____ Personal Email Address_____

GENERAL INFORMATION:

Gender (Circle One): Male or Female Age (Circle One): 16-17 18-24 25-39 40-54 55+

DEMOGRAPHIC INFORMATION:

Race (Circle One): Caucasian African American Asian Hispanic Native American Other _____

Marital Status (Circle One): Single Married Divorced Widowed

Dependents: How many children do you have legal custody of? _____ Household Size (including self)_____

Income: Do you currently receive any of the following assistance? (Circle all that apply)

Cash Assistance [Welfare, TANF, OWF, etc.] Food Stamps WIC Child Care Public Housing

Child Support SSI/Disability Alimony Worker's Compensation Medicaid/Medicare Unemployment

What is your personal total annual [yearly] income? *Count all sources including day care & food stamp benefits.*

$0-$9,999 $10,000-$14,999 $15,000-$19,999 $20,000-$29,999 $30,000 and above

What is your household total annual [yearly] income? *Count all sources including day care & food stamp benefits.*

$0-$9,999 $10,000-$14,999 $15,000-$19,999 $20,000-$29,999 $30,000 and above

EDUCATION: (Circle all that apply)

GED High School Diploma Vocational Training Associate Degree Bachelor Degree

If you do *NOT* have a GED/High School diploma list: Last grade completed _____ High School attended _____

Other Certification Programs/Post-HS programs _____ [year certificate was received] _____

WORK HISTORY:

Military Service (Circle One): Active Duty Reserves National Guard Veterans

Employment**:** Are you currently employed? (Circle one) Yes No If yes, where? _____

City where employed: _____ Start Date _____ Full-time Part-time PRN/On Call/Varies/Seasonal

In the last 2 years, have you or a parent worked within the agriculture field? i.e. Farming, cannery, dairy, Christmas tree farm, greenhouse or nursery? (Circle one) Yes No If yes, describe? _____

Insurance**:** Health insurance? Yes No Dental Insurance? Yes No Vision insurance? Yes No

I hereby acknowledge that my statements above are true and correct. I understand that false or inaccurate information will be basis for termination from the training program. I authorize Quality CNA Training to release this information form to my potential employers and other organizations that may offer scholarships. My complete training program file including: graduation, state testing, employment and above demographic data may be released to my funding source third party provider, case**w**orker or potential employer, if requested.

Student Signature _____ Date _____

QUALITY CNA TRAINING LLC
NURSE ASSISTANT TRAINING PROGRAM

SELF-ASSESSMENT HEALTH FORM

(To be filled out by applicant upon registration)

NAME:_____DATE OF BIRTH:_____

ADDRESS:_____PHONE:_____

PERSONAL PHYSICIAN:_____

NAME & PHONE # OF WHO TO CALL IN CASE OF AN EMERGENCY_____

DATES OF CURRENT FLU SHOT & TB Tests: *(Please provide documentation on the following page)* _____

HISTORY OF/DISEASE OF: (Put a check mark next to those you had or do have)

_____BONE	_____FREQUENT HEADACHES
_____JOINTS	_____FREQUENT SORE THROAT
_____BACK (SPINE)	_____FREQUENT COLDS
_____SKIN	_____CHRONIC SINUS INFECTION
_____SEIZURES	_____ASTHMA
_____ARTHRITIS	_____BRONCHITIS
_____DIABETES	_____HEART CONDITION
_____TUBERCULOSIS	_____THYROID CONDITION
_____HEPATITIS	_____DEPRESSION/ANXIETY
_____HYPERTENSION	_____NERVOUS/MENTAL ILLNESS
_____HERNIA	_____ OPERATIONS
_____INJURIES	_____ OTHER SERIOUS ILLNESSES

PLEASE EXPLAIN ALL ITEMS CHECKED ABOVE_____
_____
_____
_____

1. DO YOU HEAR WELL?_____DO YOU SEE WELL?_____

2. DO YOU HAVE ANY ALLERGIES?_____
   IF YES, PLEASE EXPLAIN_____

3. ARE YOU CURRENTLY TAKING ANY MEDICATION?_____
   WHAT AND FOR WHAT REASON?_____

4. DO YOU HAVE A LIFTING RESTRICTION? (A DOCTOR'S RELEASE NEEDED IF YES)_____

5. PREGNANT? (A DOCTOR'S RELEASE NEEDED IF YES)_____

6. DO YOU HAVE ANY DEFECT, DEFORMITY, PROBLEM, OR DISEASE WHICH MAY INTERFERE WITH YOUR PARTICIPATION IN THE NURSE ASSISTANT TRAINING PROGRAM?_____
   IF YES, PLEASE EXPLAIN_____

7. STATE DETAILS OF ILLNESSES, INJURIES, OPERATIONS OR DEFECTS:_____
   _____

I, the undersigned, certify the above answers and statements are true. I am in good health with no communicable disease, and physically able to perform the duties of a nurse assistant. I do hereby release this information to the Quality CNA Training LLC Training Program administration and its instructors.

STUDENT SIGNATURE_____ DATE:_____

NOTE: Parental / Guardian signature required for students is under the age of 18:

PARENT SIGNATURE_____ DATE:_____

***PLEASE NOTE:* A 2-Step TB test takes a FULL 14 days and involves two injections & two readings. A blood test or chest xray can be done in place of the TB. This form needs to be returned on the first day of class unless prior arrangements have been made with Student Services.**

Quality CNA Training LLC – Nursing Assistant Student
Flu Shot & Mantoux 2 Step Tuberculin Skin Test Record or Chest X-Ray Report

The TB skin test (also called the Mantoux tuberculin skin test) is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. *A person given the tuberculin skin test must return within 48 to 72 hours to have a trained health care worker look for a reaction on the arm*. The health care worker will look for a raised, hard area or swelling, and if present, measure its size using a ruler. Redness by itself is not considered part of the reaction. Some people are allergic to the TB skin test or have been infected by the TB bacteria in the past. This means the person's body was infected with TB bacteria. Additional tests are needed to determine if the person has latent TB infection or TB disease. A health care worker will then provide treatment as needed. For more information please visit the CDC website http://www.cdc.gov/TB/TOPIC/testing/default.htm.

Student Information

Student Name: _____

Student Address: _____

City:_____State_____Zip:_____Telephone:_____

Date of Current Flu Shot *(Must be within the last 12 months – Only needed between Oct – March)*

Date: _____ Signature of Provider: _____

Skin Test Information (1st Step): Administrator By: _____

Date/Time Administered: _____ Location:_____

Manufacturer:_____ Expiration Date:_____ Lot#:_____

Results (1st TST Reading Date Required)

Induration: _____ mm Date/Time of Reading: _____

Comments/Adverse reaction(s) if any: _____

Name of Reader:_____ Signature of Reader: _____

Skin Test Information (2nd Step) Administrator By: _____

Date/Time Administered: _____ Location:_____

Manufacturer:_____ Expiration Date:_____ Lot#:_____

Results (2nd TST Reading Date Required)

Induration: _____ mm Date/Time of Reading: _____

Comments/Adverse reaction(s) if any: _____

Name of Reader:_____ Signature of Reader: _____

Chest X-RAY Information *(is ONLY needed if traditional TB test is positive or as an alternative to traditional TB Test)*

Date film: _____ Hospital/Facility film taken:_____

Interpretation

_____ Completely Negative

_____ Negative; Except for: _____

_____ Abnormal; Reason: _____

Quantiferon Gold TB Blood Test Information *(is ONLY needed if traditional TB test is positive or an alternative to TB Test)*

Date given: _____ Results:_____

Name of Radiologist/Physician: _____

Signature of Radiologist/Physician: _____ Date of Reading _____

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Refer to DQA form F-82064A, *BID Instructions,* for additional information.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- **PRINT OR TYPE YOUR ANSWERS.**

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Household member (lives on premises, but is not a client)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Other – Specify: _____

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*	
Position Title (Complete only if a prospective or current employee or contractor.)		Birth Date *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown		Social Security Number	
Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.
   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.
   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?
   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.
   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.
   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**

Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? Yes ☐ No ☐

If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? Yes ☐ No ☐

If **Yes,** explain, including when and where it happened.

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**? Yes ☐ No ☐

If **Yes**, explain, including when and where it happened.

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? Yes ☐ No ☐

If **Yes**, explain, including credential name, limitations or restrictions, and time period.

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened.

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? Yes ☐ No ☐

   If **Yes,** explain, including when and where it happened and the reason.

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? Yes ☐ No ☐

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

4. Have you resided outside of Wisconsin in the last three (3) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

   If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

   If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted