



Mid-Coast School of Technology Adult Education

*1 Main Street
Rockland, ME 04841
Tel: (207) 596-7752 ext. 3
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Certified Nursing Assistant Program

Classes meet 9 weeks on Tuesdays, Wednesdays & Thursdays.

___ July 1, 2026 ___ Sept 8, 2026 ___ Nov 17, 2026 ___ March 23, 2027

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 the 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 \$1,350 (subject to change) and includes \$21 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: _____

Tel #1: _____

Address: _____

Tel #2: _____

(Must provide emergency alternate #)

Soc. Sec # _____

Town and Zip Code

Date of Birth _____

Email: _____

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

High School: _____ Are you a high school graduate? _____

College: _____ Are you a college graduate? _____

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? Yes___ No___

If yes, please describe. _____

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

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

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

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

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 or 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 from MYCHART system (includes an annual flu vaccine and 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)

How to Complete the Required Background Check

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.

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 _____
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UNIVERSAL IMMUNIZATION VERIFICATION CHECKLIST

For individuals who are not employed by the clinical organization
who will be in-person for at least 3 days (24 cumulative hours) in a calendar month.

Section A: Required Immunizations (All learners) (MH-MaineHealth)		Required by:
		MH
1. 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		
2. 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		
3. Influenza (annual requirement for rotations during influenza season)		✓
• One dose of seasonal vaccine annually (received on or after 8/1 for the season)		
Section B: Immunizations (Required for All learners in clinical settings)		Required by:
		MH
4. Tdap (tetanus, diphtheria, and pertussis) or Td (tetanus, diphtheria)		✓
One dose of vaccine < 10 years ago		
5. Hepatitis B		✓
• Two or three vaccine doses depending on brand -OR-		
• Immunity by positive blood titer		
6. Other Immunizations. Individual healthcare organizations may require other vaccines		
Section C: Tuberculosis Screening (Required for All learners in clinical settings)		Required by:
		MH
• An Interferon-Gamma Release Assay (IGRA) blood test for TB infection in the last 12 months -OR-		✓
• 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		
• 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		
Other screenings. Individual healthcare organizations may require other screenings.		

Verification may occur:

- Through the supervisor assigning work to the individual (documentation available upon request), or
- By the student directly entering information into a centralized data tracking system approved by the clinical site.
- Once for all immunizations except those required annually, or when a booster dose is required.

Approved Verification Processes for Centralized Data Tracking System:		Accepted by:
		MH
1. Data uploaded into the centralized data tracking system with credentials of provider submitting records being an MD, DO, NP, PA, RN, or other providers authorized to administer vaccines, such as RPh or PharmD.*		✓
2. Third party verification with sample audits		✓
3. Data uploaded into centralized data tracking system in the form of a recognizable Electronic Health Record.		

*Verification Procedures: (1) Naturopathic providers (ND) cannot submit exemptions. (2) Providers cannot submit records on their own behalf (3) Providers reviewing official patient records created by another practitioner, which indicate that a particular patient received a vaccine on a specific date, including the month and year, may verify immunization status for an individual. (4) Adequately prepared secondary school or collegiate health records will be accepted as proof of immunization, including immunization records from health professionals' schools such as medical school or nursing school. Reference:

<https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm>

UNIVERSAL IMMUNIZATION VERIFICATION FORM
For individuals who are not employed by the clinical organization

A licensed MD, DO, NP, PA, RN, or other 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: _____

Section A: Required for all learners

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

Immunization	1 st dose (mm/dd/yy)	2 nd 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): _____

Section B: Required for all learners in clinical settings

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

Section C: Required for all learners in clinical settings

Tuberculosis screening:

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

--OR--

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): _____

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

Signature of provider

Printed name of provider

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

Provider office phone number: _____