P.O. Box 1101, Yuba City, CA 95992
530-301-2582 · support@hi-poweracademy.com

Requirements checklist

Staff initials each row. Attach copies where a copy is required.

Requirement	What is required	Yes	No
Government ID	Copy of a driver's license, DMV ID, passport, or green card.		
Social Security	Copy of the Social Security card.		
Age	At least 16.		
Education	High school diploma or a recognized equivalent, such as a GED. International credentials must be evaluated.		
Fees	$1,533.15 paid to the school.		
Enrollment form	Signed and returned.		
Contract	Signed and returned.		
Background check	Live Scan completed.		
CPR and first aid	Current CPR card.		
Physical	Exam within the last 9 months.		
TB test	Two-step PPD within the last 9 months, or a chest X-ray, or a QuantiFERON test if the PPD is positive. An X-ray or QuantiFERON must be valid per the physician.		
Hepatitis B	Vaccine given, or the declination form signed.		
Flu	Flu shot for the season from November 1 to March 30, or the declination form signed.		
Drug test	Completed within the last 14 days, if the clinical site requires it.		
MMR	Copy of the vaccine or titer, or a physician note if declined.		
Tdap	Copy of the vaccine or titer, or a physician note if declined.		
Varicella	Copy of the vaccine or titer, or a physician note if declined.		

Student name: _____

Student signature: _____ Date: _____

Official use only. Approved: Yes / No Date: _____

Comments: _____

Signed by: _____

P.O. Box 1101, Yuba City, CA 95992
530-301-2582 · support@hi-poweracademy.com

Physical examination

For participation in the vocational program. The clinician completes this page.

Patient's Name: _____ Date of birth: _____

Date of examination: _____ Gender (circle one): Female / Male

Height: _____ Weight: _____ BMI: _____ Blood pressure: _____

Heart rate: _____ Respiratory rate: _____ Temperature: _____

General appearance, posture, mobility: _____

Head, eyes, ears, nose, throat: _____

Lung sounds and breathing: _____

Range of motion: _____ Strength: _____ Lifts 10 pounds: _____

Reflexes, sensory, motor, coordination: _____

Can this student perform the essential motor and sensory functions required of students entering the medical field? ☐ Yes ☐ No

Physician recommends: _____ Full Release _____ Not Released

The student does not have any health conditions that would create a hazard to themselves, fellow employees, or patients. ☐ Yes ☐ No

Physician name or stamp: _____

Physician signature: _____ Date: _____

Hepatitis B declination

Patient's Name: _____ Date of birth: _____

Gender: _____ Date: _____

I understand that my work may expose me to blood or other infectious material, and that I may be at risk of hepatitis B. I have been told about the hepatitis B vaccine. I choose:

☐ I was immunized before and do not need the vaccine again.

☐ I decline the vaccine at this time.

If I decline, I understand the risks, including liver infection, cirrhosis, liver cancer, and death. I may ask for the vaccine later.

Patient's Signature: _____ Date: _____

Witness name, title & Signature: _____ Date: _____

Two-step PPD

Full name: _____ Date of birth: _____

Gender: Female / Male Date this form was completed: _____

Step 1

Date given: _____ Location: _____ Given by: _____

Lot number: _____ Expiration: _____

Date read (48–72 hours): _____ Result: ☐ Positive ☐ Negative Induration (mm): _____

Read by: _____

Step 2

1 to 3 weeks after step 1.

Date given: _____ Location: _____ Given by: _____

Lot number: _____ Expiration: _____

Date read (48–72 hours): _____ Result: ☐ Positive ☐ Negative Induration (mm): _____

Read by: _____

Final reading: ☐ Positive ☐ Negative Follow-up required: ☐ Yes ☐ No

STATE OF CALIFORNIA
DEPARTMENT OF JUSTICE
BCIA 8016 (Rev. 04/2020)

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City | State | ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name Middle Initial Suffix

Other Name (AKA or Alias) Last Name

First Name Suffix

Date of Birth Sex: ☐ Male ☐ Female

Driver's License Number

Date of Birth

Height | Weight | Eye Color | Hair Color

Billing Number (Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number (Other Identification Number)

Home Address Street Address or P.O. Box

City | State | ZIP Code

I have received and read the included Privacy Notice, Privacy Act Statement, and Applicant's Privacy Rights.

Applicant Signature

Date

Your Number: OCA Number (Agency Identifying Number)

Level of Service: ☐ DOJ ☐ FBI
(If the Level of Service indicates FBI, the fingerprints will be used to check the criminal history record information of the FBI.)

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Street Address or P.O. Box

City | State | ZIP Code

Telephone Number (optional)

Mail Code (five digit code assigned by DOJ)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

STATE OF CALIFORNIA
BCIA 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES
REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1226
ORI (Code assigned by DOJ)

Certification
Authorized Applicant Type

Certified Nurse Assistant (CNA) or Home Health Aide (HHA)
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

California Department of Public Health (CDPH)
Agency Authorized to Receive Criminal Record Information

03314
Mail Code (five-digit code assigned by DOJ)

MS 3301, P.O. Box 997416
Street Address or P.O. Box

(Leave blank)
Contact Name (mandatory for all school submissions)

Sacramento | CA | 95899-7416
City | State | Zip Code

(Leave blank)
Contact Telephone Number

Applicant Information:

Your last name
Last Name

Your first name & middle initial
First Name Middle Initial Suffix

Other last names known as
Other Name (AKA or Alias) Last

Other first names known as
First Name Suffix

Date of Birth Sex: ☐ Male ☐ Female (Check one)

California Driver's License Number
Driver's License Number

Date of Birth

Billing Number

Not Applicable
(Agency Billing Number)

Height | Weight | Color | Color
Height | Weight | Eye Color | Hair Color

Misc. Number

Your telephone number
(Other Identification Number)

Place of Birth
Place of Birth (State or Country)

*Social Security Number (Required by CDPH)
Social Security Number

Your mailing address
Home Address Street Address or P.O. Box

City | State | Zip Code

Your Number: *Social Security Number (Required by CDPH)
OCA Number (Agency Identification Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list ATI number:
(Must provide proof of Rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)
Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City | State | Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

BCIA 8016 (Rev 07/11) SAMPLE
ORIGINAL - Live Scan Operator

SECOND COPY - Applicant

THIRD COPY (if needed) - Requesting Agency

NOTE TO APPLICANT: *Please input your Social Security Number (SSN) where required. The submission of your SSN will allow results to be transmitted from DOJ to CDPH accurately and timely. Failure to submit your SSN could cause delay in your certification.