

Community Health Aide Basic Training Application

Application for Session #: _____

Date application updated: _____

To be completed by the field supervisor and the CHA. This application must be received by the training center at least four weeks before the start of the session. Please complete both sides of the form.

Name: _____

Last
First
MI
CHAPCB Certificate #

Mailing address: _____

PO Box or Street
City
State
Zip

Birth date: _____ Phone #'s: _____

Cell
Home
Clinic
Fax

CHA email address: _____

Training levels of health care providers in clinic: _____

Employer: _____ Village: _____ Population: _____

Field Supervisor: _____ Field Supervisor Phone: _____

Field Supervisor email: _____

Field Supervisor Address: _____

PO Box or Street
City
State
Zip

CHAP Director's name: _____

CHAP Director's phone: _____ Director's email: _____

EDUCATION:

HS graduate/GED date: _____ or Highest grade completed: _____ Post high school courses or degree: _____

TABE 11/12M Test: Reading Grade Level: _____ Math Level: _____ If not 11/12M, specify which TABE: _____

CHAP Medical Math Assessment completion date: _____ CHAP Medical Math Checklist attached: Yes No

EMS Training: ETT <i>or</i> EMT		ETT Exp:		EMT Exp Date:		
Pre-Session Course	Date:	Location:				
Basic Training	Month/Year Completed & Location	Pass	No Pass	CHAP CB Certified		Cert Exp Date
Session I				Yes	No	
Session II				Yes	No	
Session III				Yes	No	
Session IV				Yes	No	

Training/Classes since last session: _____

Other Work Experience: _____

Native language is spoken in your village: _____ Do you speak this? Yes No

Completed eCHAM Training? Yes - Date of training: _____

No - Date training will be completed: _____

