Southern New Hampshire Area Health Education Center

New Hampshire Needs Caregivers!
PROGRAM APPLICATION AND AGREEMENT
For students under age 18

First Name:_____Middle Initial: _____

Last Name: _____

Phone Number (e.g., 603-123-4567): _____

Email Address: _____

Address: _____

City:_____State:_____Zip: _____

Date of Birth (e.g., 12/07/1999): _____

Education (highest level completed):__ How did you hear about us? _____

What is your ethnicity? *(please select one)*

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

What is your race? *(please select one)*

- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian: Chinese, Filipino, Japanese, Korean, Asian Indian or Thai
- ☐ Asian (other than above)
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Unknown
- ☐ More than one race

Please indicate your gender:

____ Female ___Male ___Non-binary/third gender ___Other ___Prefer not to say

NH Needs Caregivers Program Agreement

PLEASE REVIEW AND PLACE YOUR INITIALS ON THE LINE NEXT TO EACH STATEMENT BELOW

_____ Agrees to share information and allow information sharing with the University of Wisconsin Oshkosh (UWO), Southern New Hampshire Area Health Education Center (SNHAHEC), participating facilities/ healthcare settings and participating training programs for purposes of the NH Needs Caregivers Program.

_____Agrees to register for an approved Nurse Aide training program within 90 days of completing the registration survey. (SNHAHEC/ NH Needs Caregivers Program website has a listing of participating training programs)

_____Agrees to forward email received upon NH Needs Caregivers Program registration to the approved Nurse Aide training program.

_____Agrees to successfully complete an approved Nurse Aide training program.

_____Agrees to schedule competency test within three months of completing training.

_____Agrees to successfully complete competency testing within two attempts.

_____Agrees to secure employment in a participating facility/ healthcare setting in New Hampshire within two months of completing competency testing.

_____ Agrees to respond to requests from NH Needs Caregivers Program Director regarding training and employment via email and/ or phone.

_____Agrees to participate in a secure online survey at the conclusion of participation in the NH Needs Caregivers Program.

_____I understand that payment of the $500 retention bonus after working at a participating NH Needs Caregivers Program facility (employer) for six (6) continuous months is the sole responsibility of the employer. I agree to release from liability: Lamprey Health Care, Southern New Hampshire Area Health Education Center (SNHAHEC) and NH Needs Caregivers Program for any and all claims related to the failure to pay the retention bonus.

Thank you for completing the Program Application and Agreement. NH Needs Caregivers will enter this information into our database, after which you will receive an email with your participant ID number. Please keep the email and your ID number as you will need to provide it when you apply for employment at a participating facility/ healthcare setting and qualify for the $500 bonus. Questions? Please contact Lynn Carpenter, Program Director at Lynn@navlynresources.com.

Student Signature:_____Date: _____

Parent Printed Name: _____

Parent Signature: _____
(if under 18)

After signing, please return this form to the Southern New Hampshire Area Health Education Center via US Mail or email:

US Mail:
Lynn Carpenter
Program Director, NH Needs Caregivers
1031 Loudon Ridge Road
Loudon, NH 03307

Email:
lynn@navlynresources.com