



Texarkana College Community Education Allied Health Programs

Certified Nurse Aide (CNA) Program with Clinical Externship

The Certified Nurse Aide Course at Texarkana College prepares students for the Texas state certification exam. This 100-hour program equips entry-level nursing assistants with the knowledge and skills needed to provide essential care to patients and residents in hospitals, assisted living, and long-term care facilities. Prior approval of all required documentation must be completed before acceptance into the program.

Program Schedule

- Dates & Times: **September 8, 2026 – December 3, 2026**
- Length: 12 weeks / 100 classroom hours + 44-hour clinical externship
- Evenings: Mondays, Tuesday s, Thursdays — 5:00 PM to 9:00 PM
- Location: TC Campus, Health Sciences Building, Room 255



Program Details

- Tuition: \$700 (Textbooks included)
- Payment plans available (first payment \$175 + \$30 processing fee) Credit/debit card required
- Not eligible for FAFSA (non-credit program)

Registration

- Register in person at the Community Education Center in the Nelson Administration Building.
- Online registration is not available.
- Deadline to register or drop: **Friday, September 4, 2026, by 3pm.**
- Enrollment may close early if class reaches capacity.

Refund Policy

Students who wish to drop this course may receive a 100% refund upon request (excluding the \$30 processing fee) on or before the drop date.

State Certification Exam

Students receive instructions on applying for their state exam. Written and skills exams are paid for online and can be scheduled at the Texarkana College Regional Testing Site.

Criminal Background Requirements

Students with a criminal background may be prevented from becoming licensed by the State of Texas. Students should verify concerns with the Texas Nurse Aide Registry (512-438-2050). A social security number is required for the required Pre-Check background process.

Clinical Externship Checklist

Important: Students must complete and submit required prerequisite documentation. Why is this required? Clinical externship hours begin shortly after the course starts. To be eligible for clinical placement, all prerequisite documentation listed below must be completed and submitted before **the second night of class.**

- ☐ Report of Employee Misconduct (completed by Allied Health Director)
- ☐ Physical Exam Report (approx. \$69)
- ☐ Immunization Records: Hep B (3-shot series), MMR, Varicella, Tdap (within 10 years)
- ☐ Negative TB Test or chest X-ray (within 6 months)
- ☐ Current Drug Screen (within 30 days of class start)
- ☐ Background Check Authorization Form
- ☐ Black scrub bottoms / White scrub tops (required for clinical)
- ☐ Liability Insurance – \$20 (purchase at TC Business Office)
- ☐ State Exam Fee – \$125 (paid online when scheduling exam)

I understand and acknowledge the requirements above must be completed and submitted within the time limit stipulated by the Allied Health Director.

Student Signature

Date

Review and approved by:

Allied Health Coordinator

Date

Contact Us

For questions regarding enrollment or course information, please contact Nancy Lambert at 903-823-3382 or nancy.lambert@texarkanacollege.edu.

Holli Easley
Director of Community Education/Allied Health
903-823-3276
holli.easley@texarkanacollege.edu.

TC does not discriminate on the basis of race, color, national origin, sex, disability or age in its programs, activities, admission or employment. The following person has been designated to handle inquiries regarding the nondiscrimination policies: Director of Human Resources/Title IX Coordinator, 2500 N. Robison Rd., Texarkana, TX, 75599, (903) 823-3006, human.resources@texarkanacollege.edu.

TEXARKANA COLLEGE
COMMUNITY & BUSINESS EDUCATION – Allied Health Program

PHYSICAL EXAMINATION FORM

Name _____
Last First Middle (Maiden)

Single _____ Married _____ Widowed _____ Date of Birth _____ Male _____ Female _____

Address _____
Street/P.O. Box City State Zip Code

Name & Address of Nearest Relative _____

Medical History: (To be completed by student):

1. Serious illness - give diagnosis & date _____
2. Operations - give diagnosis & date _____
3. Do you have any allergies? If so, what? _____
4. Do you have any physical disorders at present? _____
5. Do you have any emotional disorders at present? _____
6. What prescribed & unprescribed medications are you taking? _____
7. Have you had any severe injuries? If so, what? _____

8. Check any of the following conditions you have had:
- | | | | | | |
|-----------------|-------|--------------------------|-------|---------------------|-------|
| Hay Fever | _____ | Infectious Mononucleosis | _____ | Tuberculosis | _____ |
| Asthma | _____ | Hepatitis | _____ | Arthritis | _____ |
| Rheumatic Fever | _____ | Fainting Spells | _____ | Kidney Disease | _____ |
| Heart Murmur | _____ | Diabetes | _____ | Emotional Disorder | _____ |
| Poliomyelitis | _____ | Epilepsy | _____ | Chemical Dependency | _____ |

9. Name & address of personal physician _____

PHYSICAL EXAMINATION (To be completed by your family physician or certified Nurse Practitioner)

Weight _____ Height _____ Skin Abnormalities _____
Eyes ® _____ (L) _____ Corrected to ® _____ (L) _____ Ears ® _____ (L) _____
Throat _____ Nose _____ Neck _____ Lungs _____
Breasts ® _____ (L) _____ Heart _____ Nodes _____
Abdomen _____ Hernia _____ Pulse Rate _____
Blood Pressure _____ Defects Found? _____
Corrections Recommended _____
Any Reason for Limitation of Physical Activity? _____
Any Reason for Limitation of Health Care Activity? _____

Signed _____

Print name and title _____

Date _____



Request for Testing or Treatment

Applicant: Please complete this form and bring it with you along with the physical exam form to the location listed below. Note: You are responsible for all services rendered by Healthcare Express.

Company Name: Texarkana College

Nursing, EMT/Paramedic, & Pharmacy Technician Programs

Date: _____ Time: _____

Student name: _____ SS #: _____ TCID# _____

Please perform the following procedure(s) for the above program applicant: D

☐ Urine Drug Test ☐ Physical Exam

☐ TB Skin Test ☐ Hepatitis B Titer ☐ Varicella Titer

☐ Flu Vaccine _____

☐ Other Vaccine: _____

This is a Non-DOT Procedure

Reason for services: Pre-admission requirement for a college program.

Patient is responsible for all services rendered.

Please send results to: holli.easley@texarkanacolleg.edu (903-823-3276)

HealthCare Express
3515 Richmond Road | Texarkana, Texas 75503
903-791-9355



APPLICANT AUTHORIZATION OF BACKGROUND CHECK

You are authorizing Texarkana College (TC), to conduct a background check in connection with your potential employment with TC. The background check may include, but is not limited to, criminal history, employment verification, academic credentials, licensures, certifications, registrations, professional designations, personal references, and professional references.

Any offer of employment extended to you by TC is contingent upon the results of this background check. Your eligibility for employment at TC is determined by TC at its sole discretion. You agree to hold harmless all Texarkana College personnel, including but not limited to, its Trustees and Administrators for any adverse information discovered as a result of this background check.

You agree to fully and freely provide any and all necessary information to Texarkana College, or its assigned agents, so that this background check may be conducted.

By your signature below, you acknowledge that you have read and agree to the terms stated above. You further agree to provide the information as requested below.

I authorize Texarkana College to conduct a background check on me, and, if I am hired, at any time during my employment.

I understand that I may withhold my permission and that in such case, no investigation will be done, and my application for employment will not be processed further.

Printed Full Name: _____ Maiden Name: _____

Position Applied for: _____

Race: _____ Gender: _____ Date of Birth (mm/dd/yyyy): ____/____/____

Aliases and all names used and corresponding years: _____

Driver's License Number: _____ State of Issue: _____ Social Security Number: **** - ***- _____

I, _____, acknowledge that a Computerized Criminal History (CCH) check may be performed by accessing the Texas Department of Public Safety Secure Website and may be based on name and DOB identifiers. Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411, Subchapter F.

*Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history record information (CHRI), **therefore the organization conducting the criminal history check is not allowed to discuss with me any CHRI obtained using the name and DOB method.** The agency may request that I also have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.*

In order to complete the fingerprint process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at <https://www.dps.texas.gov/section/crime-records/crime-records-general-information> /Review of Personal Criminal History or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of \$25.00 to the fingerprinting services company. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

Signature: _____ Date: _____

For Office Use only:
Texarkana College

Agency Name	Agency Representative	Representative Signature	Date	Purpose
-------------	-----------------------	--------------------------	------	---------