CABARRUS COLLEGE of HEALTH SCIENCES

CONTINUING EDUCATION REGISTRATION FORM

Print in black or blue ink or type all information below:

For which course are you applying? (Only one course per form) _____

Course #: _____ Section #: _____ Date course begins: _____ Date course ends: _____

PERSONAL:

Name: _____
(Last) (First) (Middle/Maiden Name)

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Name you prefer to be called: _____ County of Residence: _____

Mailing Address: _____
(Number and Street Address) (City) (State) (Zip)

Parent or Guardian Name _____ Phone _____
(if student is under age 18)

Emergency Contact Name _____ Relationship _____

Phone Number _____

GENDER	ETHNIC GROUP/RACE	
☐ Female ☐ Male	☐ Hispanic of any race For non-Hispanic only: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Two or more races

1. Are you a U.S. Citizen? **(If no, you must present a valid I-551 or Permanent Resident Card)** _____

English is my native (first) language. Yes No*

*If English is not your native language, a TOEFL score of at least 220 (computer version) or 83 (iBT: Internet based) is required to process your application. Please contact www.toefl.org to schedule test or request scores. (Cabarrus College School Code 550).

2. Are you an employee of CMC-NE or one of its affiliate **OR** a CCHS student? ☐ **Yes** ☐ **No**

3. Have you ever been arrested, charged with or convicted of a criminal offense other than a minor traffic violation? ☐ **Yes** ☐ **No**
If yes, are such criminal charges pending against you at this time? Please attach an explanation describing the circumstances and current status of such arrests, charges or convictions. Certain misdemeanors and/or felonies may make a graduate ineligible for professional certification/licensure.

REFUND POLICY

1) **Registration fee is refunded if the class is cancelled due to insufficient enrollment.**
2) **Background check fee in non-refundable**
3) **Registration fee is <u>not</u> refunded if the student fails to attend class or withdraws after course withdrawal deadline. Course substitutions prior to the first class meeting will be considered. Please call 704-403-2216.**

CABARRUS COLLEGE of HEALTH SCIENCES

CONSENT FOR RELEASE

The purpose of this release is to provide documentation of drug screen results, immunizations, and background checks to clinical facilities that are part of the educational programs of the College.

Drug Screen Results and Immunization Record
My signature below hereby authorizes, without reservation, Cabarrus College of Health Sciences to release my immunization record and my drug screen results and any related information to agencies providing clinical experiences for my educational program as necessary in the normal course of business. In addition, I hereby waive any and all claims or causes of action that I may have against the College of any clinical affiliation sites, resulting from the release of such information. This authorization will expire at the completion of my educational program unless previously revoked.

Consumer Reports (Background Check)
In connection with my admission to Cabarrus College of Health Sciences, I understand that consumer or investigative consumer reports which may contain public record information, may be requested or made on me including criminal records, driving record, education, prior employer verification, workers compensation claims and others. Further I understand that you will be requesting information from various Federal, State, and Local agencies regarding my past activities. I also understand that the information below regarding sex, race, and date of birth is requested for the sole purpose of gathering the above information correctly, and will not be used to discriminate against me in violation of any law.

If negative information resulting in a change of my status with the College is contained in my report, I understand that I will be notified of such information by the Dean, Student Affairs and Enrollment Management. I understand that information contained in the criminal background report might result in the termination of my enrolled status. I also understand that any such termination may be appealed to the Dean, Student Affairs and Enrollment Management. I understand that I have a right to review the information that the College receives in this criminal background investigation by putting a request in writing, and that I may respond to the information. I understand that all reasonable efforts will be made by the College to protect the confidentiality of this information.

I hereby release those individuals or companies from any liability or damage in providing such information. I hereby further release the College and its agents and employees from any and all claims, including by not limited to claims of defamation, invasions of privacy, wrongful termination, negligence or any other damages of or resulting from or pertaining to the collection of this information. I understand I have the right to make a request of the Consumer Reporting Agency, upon proper identification and the payment of any authorized fees, the information in its files on me at the time of my request. I further authorize ongoing procurement of the above mentioned reports at any time during my enrollment in the College.

My signature below hereby authorizes, without reservation, any party or agency to furnish the above mentioned information and the College to share the results with agencies that provide clinical experiences related to my educational program as necessary in the normal course of business. This authorization will expire at the completion of my educational program unless previously revoked.

Signature:_____ Date:_____

FOR IDENTIFICATION PURPOSES: PLEASE PRINT ALL INFORMATION CLEARLY

_____
Last Name **First Name** **Middle Name**

Other Names: Maiden, Aliases, Etc.: _____

Date of Birth: Month_____ Day_____ Year_____ Race _____ Gender _____

Social Security #: _____-_____-_____ Driver's License #: _____ State: _____

LIST ALL ADDRESSES FOR THE PAST TEN (10) YEARS STARTING WITH THE MOST CURRENT:

STREET	CITY	STATE	ZIP	DATES (MM/YYYY)	
				FROM	TO
1.					
2.					
3.					
4.					
5.					

Policy Acknowledgement Form

Nurse Aide I Program

_____ Initial	**Class Capacity, Cancellation & Tuition Payments** The enrollment capacity for the NA I Program has been explained to me, and I understand the importance of the commitment that I am making to attend. Furthermore, I understand that Cabarrus College of Health Sciences has the right to cancel a class if the class does not meet minimum enrollment. It has been explained to me that the registration fee and tuition must be paid in full three (3) weeks prior to the first day of class. If all tuition and fees have not been paid in full, or other arrangements with Cabarrus College of Health Sciences staff have not been made, I may be removed from the class roster.
_____ Initial	**Attendance** I understand that Cabarrus College of Health Sciences has been approved by the NC Division of Health Service Regulation to provide an NA I Program. I understand that I will not receive my Nurse Aide I certificate of completion without completing the program hours as outlined in the course materials I understand the attendance policy. **I may miss no more than eight (8) hours of class or clinical without being withdrawn from the program.** The absence must be made up at the convenience of the instructor and within 30 days of the last regularly scheduled day of class. If my absences exceed one day, I understand that I may be withdrawn from the program and that my registration fee, tuition, and book fees **WILL NOT** be refunded.
_____ Initial	**Refunds** If CCHS cancels an NA I class, I understand that I **WILL** receive a full refund for the registration fee and tuition paid. Background check fee is not refundable. I understand that if I submit a request in writing to be withdrawn from the program three (3) weeks prior to the first day of class, I **WILL** receive a refund less the registration fee and background check. I understand that if I elect to withdraw from the program and do not submit my request in writing three (3) weeks prior to the first day of class, I **WILL NOT** receive a refund for the tuition. I understand that I may not be admitted into the program if all admission requirements have not been met within three (3) weeks prior to the first day of class. If admission is denied for this reason, I **WILL NOT** receive a refund for the tuition. If I am denied admission based on my background check and/or drug screen, I understand that I **WILL** receive a refund less the registration fee and background check. However, if I am found guilty of falsifying my application, I **WILL NOT** be eligible for a refund. If I am dismissed from the program due to excessive absences or violation of any other CCHS policies, I understand that **I WILL NOT** receive a refund for the tuition.
_____ Initial	**Background and Sanctions Checks** I understand that I am obligated to inform the Director of Continuing Education of any activities that may change the results of my criminal background report. This includes, but is not limited to, arrest, charge or conviction of an offense other than a minor traffic violation.

As indicated by my initials, I have read the above statements and been given an opportunity to ask questions. My questions have been answered and I understand and accept the conditions as written. Furthermore, I understand that all financial obligations with CCHS must be met before I will be awarded a certificate of completion.

_____ _____

Print Student Name Clearly Date

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (If student is under age of 18) Date

CABARRUS COLLEGE of HEALTH SCIENCES

STUDENT INFORMATION SHEET

PLEASE PRINT CLEARLY:

Program/Course/Position:				Date	
Last Name	First			M.I.	
Street Address				Apartment/Unit #	
City	State	ZIP		County of Residence	
Home Phone	E-mail Address			Date of Birth	
Work Phone		Cell Phone		SS No.	
Current Employer					

TO BE NOTIFIED IN CASE OF EMERGENCY

Contact #1		Relationship
Address		
Home Phone	Cell Phone	Work Phone
Contact #2		Relationship
Address		
Home Phone	Cell Phone	Work Phone

PARKING REGISTRATION

Two FREE permits are issued per student. You must list information for all vehicles that you may drive on campus. Additional permits are available for $5. Place permit in lower left hand side of the rear glass. ***Failure to display permit will result in parking fines.*** Please refer to the *Cabarrus College Student Handbook* for additional parking rules.

Student/Employee's Driver's License #	State
Make & Model of **Vehicle #1**	Color
License Plate #	State
Registered Owner	
Make & Model of **Vehicle #2**	Color
License Plate #	State
Registered Owner	

DEMOGRAPHIC INFORMATION

(CCHS students only) This information is requested by the U.S. Department of Education and is used for statistical purposes ONLY:

Gender: M ☐ F ☐

Ethnic Group:

- ☐ Hispanics of any race

For non-Hispanics only:

- American Indian or Alaska Native
- Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- White
- ☐ Two or more races

To participate in SonisWeb's text messaging emergency notification system, please provide your cell phone number and provider when you update our biographic information in SonisWeb. I understand standard text rates may be charged to my cell phone provider. One test will occur each term.

I hereby certify that the above information is correct. I also understand that it is my responsibility to keep this information current with the College.

I also give Cabarrus College my permission to release information about my participation in activities, honors and awards to the local media and/or the newspaper indicated on this form.

Signature Date

FOR SECURITY USE ONLY

Decal # Vehicle #1	Date of Issuance
Decal # Vehicle #2	Date of Issuance
Parking Lot-Cabarrus College	Name of Responsible Person Assigning Decal(s)

CABARRUS COLLEGE of HEALTH SCIENCES

CONSENT FOR TREATMENT OF MINOR STUDENT

I hereby authorize CHS NorthEast, its employees or agents, and any member of its Medical staff to provide medical treatment needed by_____(name of minor) as a result of any condition, injury or illness occurring while a student at Cabarrus College of Health Sciences.

_____ _____

Signature of Parent or Guardian/Date Witness (NOT A RELATIVE)/Date

NOTE: Parents or Guardians of Minors – NC Law recognizes one's adulthood and age of responsibility as 18 years of age.

CABARRUS COLLEGE of HEALTH SCIENCES

STATEMENT OF HEALTH INSURANCE

I have been presented information regarding my requirement and responsibility to have health insurance coverage while participating in the programs of study at Cabarrus College of Health Sciences. I understand the risks involved in working with patients/clients in clinical settings and medical and/or laboratory equipment.

My current health insurance provider: _____

Policy Holder's Name: _____ Policy Holder's Employer: _____

Policy Number: _____ Group Number: _____

Insurance Company Address: _____

City State Zip

Insurance Company's Phone Number: _____

Updating Records

The above information is accurate. In the event that I change health insurance programs or no longer carry health insurance, I understand it is my responsibility to notify the College. I further understand that if I do not report any changes in my insurance status I may face disciplinary action up to and including termination from the program and/or college.

Name – Please Print	Program
Signature	Date
Witness Signature	Date

Please attach a copy of your current insurance card (front and back).

It is the student's responsibility to provide an updated copy of this card each year to the College or when your provider information changes.

CABARRUS COLLEGE of HEALTH SCIENCES

IMMUNIZATION RECORD

IMMUNIZATION RECORD

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SS#

Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. Student to confirm identifying information above is complete before submission.

SECTION A – Required Immunizations

	Doses	mo/day/year (#1)	mo/day/year (#2)	mo/day/year (#3)	mo/day/year (#4)
* DTP or Td or Tdap [1]	3				
* Tdap booster (If due update after 7/2008)					
* Td booster					
* Polio [2]	3				
* MMR (after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles [3] (after first birthday)	2			** Disease Date	Titer Date & Result
* Mumps [4]	2			*** Disease Date Not Acceptable	Titer Date & Result
* Rubella [5]	1			*** Disease Date Not Acceptable	Titer Date & Result
* Hepatitis B [6] (required for all students enrolling in clinical programs)	3				**** Titer Date & Result

Section B – Recommended Immunizations/Required for Students in Clinical Programs (all programs but HSLM & AS)

		mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Hepatitis B series only or					**** Titer Date & Result
* Hepatitis A/B combination series					
* Varicella (chicken pox) series of two doses or immunity by positive blood titer				Disease Date	**** Titer Date & Result
* Tuberculin Skin Test (PPD) (within 12 months) Report Result in mm induration	Date:				
	Read:				
* Chest X-ray, if positive PPD	Date:				
	Results:				
* Treatment if applicable	Date:				

Section C – Optional Immunizations

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b				
* Pneumococcal				
* Hepatitis A series only				
* HPV (Gardasil)				
* Other				

Signature of Physician/Physician Assistant/Nurse Practitioner — Date

Print Name of Physician/Physician Assistant/Nurse Practitioner — Date

401 Medical Park Drive – Concord, NC 28025
p. 704.403.1555 or 1556 – f. 704.403.2077

Office Address City State Zip Code

CABARRUS COLLEGE of HEALTH SCIENCES

IMMUNIZATION RECORD

**Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

***Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician is not acceptable.

****Lab Report must be submitted.

Footnote [1] - DTP (Diphtheria, Tetanus, Pertussis), DTaP (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which one must have been within the past 10 years.

Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid or tetanus/diphtheria/pertussis vaccine has not been administered within the past 10 years.

Footnote [2] - An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

Footnote [3] - Measles vaccines are not required if any of the following occur: Diagnoses of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles; or An individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

Footnote [4] - Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps; An individual born prior to 1957; or Enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

Footnote [5]- Rubella vaccine is not required if any of the following occur: 50 years of age or older; Enrolled in college or university before February 1, 1989 and after their 30th birthday; An individual who has been documented by serological testing to have a protective antibody titer against rubella.

Footnote [6] - Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.

CABARRUS COLLEGE of HEALTH SCIENCES

PHYSICAL AND EMOTIONAL HEALTH ASSESSMENT

TO BE COMPLETED BY STUDENT

Last Name	First Name	Middle Name	Date of Birth	SS#

Address	City	State & Zip

Phone (Home)	Alternate Phone	Email

Program:

Associate of Science	Medical Assistant	Nursing (ADN)	Nursing (BSN)
Surgical Technology	Medical Imaging	Pharmacy Technology	
Occupational Therapy Assistant		Interdisciplinary Health Studies/Occupational Therapy (BSIHS/MOT)	
Occupational Therapy (MOT)			

Start Date (MM/YYYY)

Signature of Student: _____ Date: _____

Please check if you have now or had in the past any of the following medical conditions:

High Blood Pressure	☐ YES	☐ NO	Chicken Pox	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO	Measles	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO	Rubella	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Mumps	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO	Hepatitis B	☐ YES	☐ NO
Lung Disease/Asthma	☐ YES	☐ NO	Hepatitis C	☐ YES	☐ NO
Any eczema/skin problems	☐ YES	☐ NO	Tetanus	☐ YES	☐ NO
Drug or Alcohol Problem	☐ YES	☐ NO	Rabies	☐ YES	☐ NO
Emotional Problems	☐ YES	☐ NO	Positive TB Skin Test	☐ YES	☐ NO
Immunity Problems	☐YES	☐NO	Drug Therapy for TB	☐ YES	☐ NO
(Lupus, HIV, Chemotherapy)			BCG Vaccine	☐ YES	☐ NO

Chronic health conditions or concerns: _____

Please list all surgeries and hospitalizations that you have had and approximate date: _____

☐ Yes ☐ No

Have you or do you currently have any of the following problems?

- Do you have areas of pain, numbness or weakness: back shoulder neck arm wrist hand hip ankle back
- Loss of balance or dizziness? _____
- Do you wear a brace or use an appliance? _____
- Experience any breathing difficulties? _____
- Recent exposures to infectious diseases? _____
- Cumulative trauma disorders, such as tendonitis or carpal tunnel? _____
- Have you ever had a back injury? If so, describe: _____
- Have you ever had lifting restrictions? Describe event, date: _____
- Based on your job description, do you currently have any physical or mental limitations and/or restrictions that would keep you from performing the essential functions of your new position? If yes, please describe or list the limitations: _____

CABARRUS COLLEGE of HEALTH SCIENCES

Please list all medications you are currently taking. (Include vitamins, herbs, over-the-counter medications, pain medications and narcotics)		
Medication	**Dosage/Frequency**	**Reason for Taking**

Please list any allergies:	☐ No known allergies
☐ Medication allergies:	
☐ Food allergies:	
☐ Latex, powder, vinyl, nitrile or dye allergies:	
☐ Other allergies:	

TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

To be completed by healthcare provider: Please read the essential functions of the college that your patient is entering and answer the questions below based on your assessment.

Essential Functions of the Cabarrus College of Health Sciences Degree and Diploma Students

1. Critical thinking ability sufficient for clinical and/or fieldwork judgment; ability to organize responsibilities, make decisions and analyze data or reports.
2. Interpersonal abilities sufficient to interact with individuals, families, and groups form a variety of social, emotional, cultural and intellectual backgrounds.
3. Communication abilities sufficient for interaction with others in verbal and written form
4. Physical abilities sufficient to move from room to room and maneuver in small places, and stand, walk or sit for extensive periods of time.
5. Gross and fine motor abilities to provide safe and effective care. Full range body motion.
6. Auditory ability sufficient to monitor and assess health needs.
7. Visual ability sufficient for observation and assessment.
8. Tactile ability sufficient for physical assessment.
9. Physical ability to lift and manipulate and/or move 45-50 pounds daily.
10. Cognitive abilities with orientation to time, place and person, ability to focus on problems and prioritize average or above intellectual functioning.

	To the Best of Your Knowledge:	
Yes No	Is the student able to perform the essential functions identified above without reasonable accommodations?	If no, please explain. If reasonable accommodations are required, please explain. Attach additional paper if necessary.
Yes No	Does this student have any disease or disorder of physical or emotional nature that could affect the safety of the client, fellow classmates, faculty, staff or himself/herself in the classroom, clinical or fieldwork setting?	If yes, please explain:
Yes No	Is the student now taking any prescribed medications?	If yes, please explain:
Yes No	Are there any additional physical or emotional factors, which you believe the college should be aware?	If yes, please explain:

CABARRUS COLLEGE of HEALTH SCIENCES

PERSONAL HEALTH MEASUREMENTS: To be completed by your PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT

BP:____/_____ Pulse: _____ Weight: _____ Height: _____ Hearing: ☐ WNL Not WNL☐

Vision: glasses/contact lenses/no correction Both eyes: 20/ _____Left Eye: 20/_____Right Eye: 20/_____

Have you had corrective surgery on your eyes: Yes ☐ No ☐ _____

Color Blindness Testing: WNL ☐ Not WNL☐ Abnormal results: Document on CHS Colorblind Testing Form

PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT NOTES:

Please Print:

Name of Healthcare Provider: _____ Title: _____

Practice/Agency: _____

Address: _____

Phone: _____Length of Time You Have Known the Student: _____

Relationship to Student: ☐ Regular Healthcare Provider ☐ Urgent Care Provider ☐ Friend/Acquaintance ☐ Other

_____

Signature of Healthcare Provider Date

CABARRUS COLLEGE of HEALTH SCIENCES

CONTINUING EDUCATION CONCURRENT/DUAL ENROLLMENT APPLICATION

Applicant must be at least 17 years old to enroll*

The completed application for enrollment and required components should be submitted to the Admissions department with the required $50 application fee. This $50 application fee is deducted from the tuition of the course taken, but is NONREFUNDABLE should you choose not to enroll.

Full Name of Student (Please Print) Email Social Security No.

Street Address Date of Birth Age

City State Phone
Zip

Name of Current High School* Current Grade Level Semester Student Intends to Enroll

*If student is home schooled, a copy of the approval letter or card from the NC Department of Non-Public Instruction must be submitted with this form. Cabarrus College of Health Sciences must also have a list of high school-level courses this student is currently taking at home.

COURSE REQUESTED:

Course Name: Number: Section:

Do you intend to apply to a degree program at Cabarrus College of Health Sciences? ☐ Yes ☐ No If so, to which program? When?

STUDENT'S CERTIFICATION STATEMENT: Read carefully.

I certify that all of my statements on this form are true and correct to the best of my knowledge and belief. I understand that falsification of information or omissions related to this form will be sufficient cause for denial of enrollment at Cabarrus College of Health Sciences. I voluntarily give the College the right to investigate my past education, employment, social background, and other activities; agree to cooperate in such investigations; and release from all liability or responsibility all persons, companies, or institutions supplying such information. I agree to conform to the rules and regulations of the College. I understand that acceptance as a concurrent/dual enrolled student does not guarantee acceptance into any program of the College. Furthermore, I understand that as a concurrent/dual enrolled student I may enroll in no more than a total of four (4) credit hours per semester. I understand I will be advised by the Coordinator for Advising & Student Success as to the applicability of courses for degree credit. I understand there are no guarantees relative to the transferability of Cabarrus College courses to other colleges/universities.

Student Signature Date

PARENT'S CERTIFICATION STATEMENT:

I am the parent or legal guardian of the above named student. I acknowledge that my child, as a college student, will be expected to adhere to all college rules of conduct. I understand that in accordance with State and Federal law, if my child is age 18 or older, I will not have the right to access my child's records without his/her written consent or court order. I understand that Cabarrus College of Health Sciences reserves the right to deny admissions to a specific course.

Parent/Guardian Signature

Date

PRINCIPAL/ GUIDANCE COUNSELOR RECOMMENDATION & CERTIFICATION:

The above named student meets the following criteria:

- Demonstrates adequate preparation in the discipline to be studied.
- Is able to benefit from college instruction.
- Has completed his/her junior year of high school.
- Has a minimum cumulative grade point average of 3.00.

Principal OR Guidance Counselor Name (Please Print)

Date

Signature

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORKING ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: 1) The same name as the passport; and 2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		
		8. Native American tribal document		5. Native American tribal document
		9. Driver's license issued by a Canadian government authority		6. U. S. Citizen ID Card (Form I-197)
		For persons under age 18 who are unable to present a document listed above:		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		10. School record or report card		8. Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI.				

Illustrations of many of these documents appear in Part 8 of Handbook for Employers (M-274).

Refer to Section 2 of the Instruction, titled "Employer of Authorized Representative Review and Verification", for more information about acceptable receipts.