**FOR DHSR USE ONLY:**

* Date DHSR Received Document From Training Program (mm/dd/yyyy):
* Status Determination of Document (Approved or Denied):
* Date Status Determination Communicated to Training Program (mm/dd/yyyy):
* Review Completed By:

|  |
| --- |
| **INSTRUCTIONS:*** Complete the form if a modification is being made to an existing State-approved training program.
* You may type your response in the space provided.
* Submit the required documentation with the form for review and approval.
* Review the [Existing Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) to ensure faculty meets the required qualifications.
* Approval from the North Carolina Division of Health Service Regulation (DHSR) is required prior to modifications being implemented in the training program.
* The Registered Nurse and the Program Coordinator or Program Administrator must sign the document.
* Email or fax completed documents to DHSR. Incomplete documents will be denied. You must submit all pages of the document.
	+ Email: DHSR.EducationConsultant@dhhs.nc.gov
	+ Fax: 919-733-9764
* Contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) with any questions or concerns.

**PROGRAM INFORMATION:**1. **Date Submitted to DHSR (mm/dd/yyyy):**
 |
| 1. **Name of School:**
2. **Name of Training Program:**
 |
| 1. **Mailing Address:**
 |
| * Street:
 |
| * City:
* Zip Code:
* County:
 |

1. **Site Address:**
* Street:
* City:
* Zip Code:
* County:
1. **Faculty Position:**

Place an X beside the correct response. Select all that apply.

* Program Coordinator and Instructor:
* Program Coordinator Only:
* Instructor Only:
1. **Training Program Number:**

Provide the training program number associated with the modification.

* Nurse Aide I Training Program:
* Nurse Aide I Refresher Training Program:
* Geriatric Aide Training Program:
* Home Care Specialty Training for Nurse Aides Program:

*Important Notice:*

Include all training program numbers associated with the modification.

1. **Applicant/Faculty Name that Appears on the Registered Nurse License:**
* First Name:
* Middle Name or Initial:
* Last Name:

|  |
| --- |
| * For the Program Coordinator position, please provide the email address:
1. **Original Registered Nurse Licensure Information:**
* State where original Registered Nurse license was issued:
* Date original Registered Nurse license was issued (mm/dd/yyyy):
* Name of college/university/school of nursing:
* Mailing address of college/university/school of nursing:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Graduation Year:
1. **North Carolina Board of Nursing (NCBON) Licensure Information:**
* License number issued by the NCBON:
* Date Registered Nurse license was issued (mm/dd/yyyy):
* License expiration date (mm/dd/yyyy):
* Is the license unencumbered?

Place an X beside the correct response.Yes:       No:      * Is the license permanent or temporary?

Place an X beside the correct response.Permanent:       Temporary:      * NCBON website verification number:

*Important Notice:* Attach the NCBON website verification to the form.1. **Compact State Registered Nurse Licensure Information:**
* State where Registered Nurse license was issued:
* Compact state Registered Nurse license number:
* Date Registered Nurse license was issued (mm/dd/yyyy):
* License expiration date (mm/dd/yyyy):
* Is the license unencumbered?

Place an X beside the correct response.Yes:       No:      * Is the license permanent or temporary?

Place an X beside the correct response.Permanent:       Temporary:      1. **Other Active State Registered Nurse Licensure Information:**
* State where Registered Nurse license was issued:
* Other active state Registered Nurse license number:
* Date Registered Nurse license was issued (mm/dd/yyyy):
* License expiration date (mm/dd/yyyy):
* Is the license unencumbered?

Place an X beside the correct response. Yes:       No:      * Is the license permanent or temporary?

Place an X beside the correct response.Permanent:       Temporary:       |
| 1. **Faculty Requirements:**

Place an X beside the correct response.Does the Registered Nurse meet the required qualifications for the requested faculty position outlined in the [Existing Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)? Yes:       No:      1. **Home Care Specialty Training for Nurse Aides Program Only:**

Provide home care/home health employment experience.

|  |  |
| --- | --- |
| **Employment Experience #1** | **Employment Experience #2** |
| Date From (mm/yyyy):        | Date From (mm/yyyy):        |
| Date To (mm/yyyy):        | Date To (mm/yyyy):        |
| Facility Name:       | Facility Name:       |
| Position:        | Position:        |
| Site Address: * Street:
* City:
* State:
* Zip Code:
 | Site Address: * Street:
* City:
* State:
* Zip Code:
 |
| Telephone (include area code):        | Telephone (include area code):        |
| Did You Work Full Time? Place an X beside the correct response.Yes:       No:       | Did You Work Full Time? Place an X beside the correct response.Yes:       No:       |
| If you worked part time, include the number of hours worked each week:       | If you worked part time, include the number of hours worked each week:       |
|  |  |
| **Employment Experience #3** | **Employment Experience #4** |
| Date From (mm/yyyy):        | Date From (mm/yyyy):        |
| Date To (mm/yyyy):        | Date To (mm/yyyy):        |
| Facility Name:       | Facility Name:       |
| Position:        | Position:        |
| Site Address: * Street:
* City:
* State:

Zip Code:        | Site Address: * Street:
* City:
* State:

Zip Code:        |
| Telephone (include area code):        | Telephone (include area code):        |
| Did You Work Full Time? Place an X beside the correct response.Yes:       No:       | Did You Work Full Time? Place an X beside the correct response.Yes:       No:       |
| If you worked part time, include the number of hours worked each week:       | If you worked part time, include the number of hours worked each week:       |

1. **Faculty Currently Employed at a North Carolina State-Approved Nurse Aide I Training Program:**

Place an X beside the correct response.Is the Registered Nurse currently employed in a faculty position at a North Carolina state-approved Nurse Aide I training program? Yes:       No:      If Yes, provide the training program name, number, position, and hire date below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Training Program Name** | **Training Program Number** | **Training Program Position** | **Training Program** **Hire Date (mm/yyyy)** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

 |
|  |

1. **Registered Nurse Employment Experience:**

Answer the questions below if the Registered Nurse is NOT currently employed in the requested faculty position at a North Carolina state-approved Nurse Aide I training program.

|  |  |
| --- | --- |
| **Employment Experience #1** | **Employment Experience #2** |
| Date From (mm/yyyy):        | Date From (mm/yyyy):        |
| Date To (mm/yyyy):        | Date To (mm/yyyy):        |
| Facility Name:       | Facility Name:       |
| Position:        | Position:        |
| Site Address: * Street:
* City:
* State:
* Zip Code:
 | Site Address: * Street:
* City:
* State:
* Zip Code:
 |
| Telephone (include area code):        | Telephone (include area code):        |
| Did You Work Full Time? Place an X beside the correct response.Yes:       No:       | Did You Work Full Time? Place an X beside the correct response.Yes:       No:       |
| If you worked part time, include the number of hours worked each week:       | If you worked part time, include the number of hours worked each week:       |
| Type of Facility: Place an X beside the correct response. Select all that apply.* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Other Please Specify:
 | Type of Facility: Place an X beside the correct response. Select all that apply.* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Other Please Specify:
 |
| Did You Supervise Nurse Aides as Part of the Job (Yes/No):        | Did You Supervise Nurse Aides as Part of the Job (Yes/No):        |
| Did You Care for Chronically Ill or Elderly (Yes/No):       | Did You Care for Chronically Ill or Elderly (Yes/No):       |

|  |  |
| --- | --- |
| **Employment Experience #3** | **Employment Experience #4** |
| Date From (mm/yyyy):        | Date From (mm/yyyy):        |
| Date To (mm/yyyy):        | Date To (mm/yyyy):        |
| Facility Name:       | Facility Name:       |
| Position:        | Position:        |
| Site Address: * Street:
* City:
* State:

Zip Code:        | Site Address: * Street:
* City:
* State:

Zip Code:        |
| Telephone (include area code):        | Telephone (include area code):        |
| Did You Work Full Time? Place an X beside the correct response.Yes:       No:       | Did You Work Full Time? Place an X beside the correct response.Yes:       No:       |
| If you worked part time, include the number of hours worked each week:       | If you worked part time, include the number of hours worked each week:       |
| Type of Facility: Place an X beside the correct response. Select all that apply.* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Other Please Specify:
 | Type of Facility: Place an X beside the correct response. Select all that apply.* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Other Please Specify:
 |
| Did You Supervise Nurse Aides as Part of the Job (Yes/No):        | Did You Supervise Nurse Aides as Part of the Job (Yes/No):        |
| Did You Care for Chronically Ill or Elderly (Yes/No):       | Did You Care for Chronically Ill or Elderly (Yes/No):       |

1. **Registered Nurse Adult Teaching Experience:**

Answer the questions below if the Registered Nurse is NOT currently employed in the requested faculty position at a North Carolina state-approved Nurse Aide I training program.

|  |  |
| --- | --- |
| **Adult Teaching Experience #1** | **Adult Teaching Experience #2** |
| Date From (mm/yyyy):        | Date From (mm/yyyy):        |
| Date To (mm/yyyy):        | Date To (mm/yyyy):        |
| Facility Name:       | Facility Name:       |
| Site Address: * Street:
* City:
* State:
* Zip Code:
 | Site Address: * Street:
* City:
* State:
* Zip Code:
 |
| Telephone (include area code):        | Telephone (include area code):        |
| Describe Experience:       | Describe Experience:       |

1. **Teaching Methodology Course/Workshop:**

Answer the questions below if the Registered Nurse is NOT currently employed in the requested faculty position at a North Carolina state-approved Nurse Aide I training program.

* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Name of Course/Workshop:
* Sponsored By:
* Mailing Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Describe Course Content:
1. **Statement of Understanding:**
* I understand the training program must meet the requirements set forth by federal and state rules, regulations, and requirements.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that students cannot perform any services to residents for which they have not been trained and found proficient by the Instructor.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the approval of a training program must be renewed by the North Carolina Division of Health Service Regulation every two (2) years.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program must use the current version of the North Carolina State-approved curriculum and adhere to the policies and procedures approved by the North Carolina Division of Health Service Regulation.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151) and [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program faculty and clinical sites must be approved by the North Carolina Division of Health Service Regulation prior to implementation and the enrollment of students.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that modifications to the training program must be approved by the North Carolina Division of Health Service Regulation prior to implementation.
* I understand modifications to the training program required by the North Carolina Division of Health Service Regulation must be made in a timely manner.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that the training program must provide supervised practical training to ensure students demonstrate the knowledge and skills required to perform nurse aide tasks and provide care under the direct supervision of a North Carolina Division of Health Service Regulation approved Registered Nurse.
* I understand the training program must incorporate innovative instructional strategies that enable students to deliver quality, compassionate, and consistent basic nursing care. I further understand the training program must ensure objectives are met through instructor demonstration, student practice and demonstration of proficiency.
* I understand the classroom must contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities.
* I understand, per [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152), that each Nurse Aide I training program laboratory must be designed, equipped, and contain a sufficient quantity of supplies as shown in the [Existing Training Program – Basic Equipment and Supply List](https://test.ncdhhs.gov/dhsr/hcpr/nat.html#TP).
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the policies for the training program must be made available to the North Carolina Division of Health Service Regulation upon request.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the training program is required to maintain student records for a minimum of three (3) years. I further understand student records must be kept onsite, kept in a locked file cabinet, kept in a locked area, and made available for review by the North Carolina Division of Health Service Regulation upon request.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program does not meet federal or state rules, regulations, and requirements.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program is not adhering to program documentation approved by the North Carolina Division of Health Service Regulation.
* I understand, per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), that the North Carolina Division of Health Service Regulation must withdraw approval of a Nurse Aide I training and competency evaluation program or a Nurse Aide I competency evaluation program if the entity administering the Nurse Aide I training program refuses to permit unannounced visits by the North Carolina Division of Health Service Regulation.
1. **Electronic Signature Agreement:**

You acknowledge and agree to the following statements:

* I certify that I have reviewed the entire document before signing.
* Your electronic signature will have the same legal effect and enforceability as your manual signature.
* No certification authority or other third-party verification is necessary to validate your electronic signature and the lack of such certification or third-party verification will not in any way effect the enforceability of your electronic signature.
1. **Attestation:**
* I have read and agree to the Statement of Understanding.
* I certify that the information in this form, and in the documentation required with the submission of this form, is truthful, accurate, and complete.
* I certify that the information in this form, and in the documentation required with the submission of this form, accurately represents the Nurse Aide I training program for which the North Carolina Division of Health Service Regulation approval is being requested.
* I will implement directives, policies, forms, and checklists as mandated by federal and state regulations and the North Carolina Division of Health Service Regulation.

**Applicant/Registered Nurse:**

First Name:

Last Name:

Signature:

Date (mm/dd/yyyy):

*Note: The North Carolina Division of Health Service Regulation will accept an electronic signature.*

**Program Coordinator or Program Administrator:**

|  |
| --- |
| *Important Notice:* If the training program is submitting the form for a Program Coordinator position, then the Program Administrator must sign the form. Otherwise, the Program Coordinator should sign the form. |

First Name:

Last Name:

Title (Program Coordinator or Program Administrator):

Signature:

Date (mm/dd/yyyy):

*Note: The North Carolina Division of Health Service Regulation will accept an electronic signature.*