**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 application if the existing State-approved training program is seeking reapproval from the North Carolina Division of Health Service Regulation (DHSR).
* You may type your response in the space provided.
* Submit the required documentation with this application for review and approval.
* Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.
* The Program Coordinator and Program Administrator must sign the application.
* 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](mailto: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):** 2. **Name of School:** 3. **Name of Training Program:** 4. **Mailing Address:**  |  |  | | --- | --- | | * Street: | | | * City: | |  * Zip Code: * County:  1. **Site Address:**  |  |  | | --- | --- | | * Street: | | | * City: | |  * Zip Code: * County:  1. **Program Administrator:**  * Name: * Title: * Telephone (include area code): * Email:  1. **Program Coordinator:**  * Name: * Telephone (include area code): * Email: * Fax (include area code):  1. **Training Program Number:**   Provide the training program number associated with the reapproval.   * 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:*  A training program reapproval application must be completed for each training program number.   1. **Program Type:**   Place an X beside the correct response.   * Community College: * Proprietary School: * State Mental Health Facility: * Nursing Home: * Hospital: * Other:       If Selected, Please Specify the Type of Training Facility:  1. **Community College Only:**   Place an X beside the correct response.   * Continuing Education: * Curriculum: * Career and College Promise: |
| 1. **Proprietary Schools Only:**  |  | | --- | | The school continues to operate under an exemption based on North Carolina General Statue [115D-87](https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_115D/GS_115D-87.pdf).  Place an X beside the correct response.  Yes:       No: |  1. **Primary Instructional Resource:**   Training programs are required to use the current version of the North Carolina State-approved curriculum provided by the North Carolina Division of Health Service Regulation.   1. **Program Hours, Course Schedule, and Supplemental Teaching Methodology (Instruction Resource):**   Provide the program (clock) hours for the training program.   * Classroom Hours: * Online Hours (if applicable): * Laboratory Hours: * Clinical Hours: * Total Program Hours:   *Important Notices*:   * The program hours, course schedule, and supplemental teaching methodologies (instructional resources) should be implemented based on the last approval by the North Carolina Division of Health Service Regulation. * A training program must be approved by the North Carolina Division of Health Service Regulation and be operational with students for at least 1 year prior to offering online classroom hours. Please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) for additional information. * The North Carolina Division of Health Service Regulation will not approve laboratory hours or clinical hours to be offered or completed online. * Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program. |

1. **Instructor/Student Ratios:**

Complete the instructor/student ratios in the table below.

|  |  |  |
| --- | --- | --- |
| Classroom: | 1 instructor per | students |
| Online (if applicable): | 1 instructor per | students |
| Laboratory: | 1 instructor per | students |
| Clinical: | 1 instructor per | students |

*Important Notices*:

* Per [21 NCAC 36.0318](http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0318.pdf), the instructor-to-student ratio for clinical cannot be greater than 1:10.
* Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Faculty:**

Identify the North Carolina Division of Health Service Regulation approved faculty associated with the training program.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Position** | **First Name** | **Middle Name or Middle Initial** | **Last Name** | **RN License Information** |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |
| Instructor |  |  |  | State:  Number: |

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Classroom:**

* Facility name:
* Room number:
* Location/Site address:
* Building:
* The classroom has tables and chairs to accommodate       students

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Laboratory:**

* Facility name:
* Room number:
* Location/Site address:
* Building:
* Number of beds:

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented in the training program.

1. **Clinical Site:**

Identify the North Carolina Division of Health Service Regulation approved clinical sites associated with the training program.

|  |  |
| --- | --- |
| **Type of Clinical Site**  (Nursing Home, Hospital, Hospice, etc.) | **Name and Location of Clinical Site** |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |
|  | County:  Name: |

*Important Notice*:

Approval from the North Carolina Division of Health Service Regulation is required prior to modifications being implemented.

1. **Student Identification:**

Students are required to wear a nametag in the clinical setting. The nametag should include the student’s name, followed by the word “Nurse Aide I Trainee” or “Nurse Aide I Student.”

The nametag should be worn facing outward.

Refer to the [North Carolina Board of Nursing](https://www.ncbon.com/badge-lawlicense-required-exceptions) for more information.

1. **Monitoring/Maintenance of Student Records:**

The Program Coordinator is required to monitor (audit) student records for accuracy. A system for monitoring student records must be in place and followed consistently.

Documents to be completed and maintained in the student record include:

* Appendix A in the state-approved curriculum
* Once completed it is optional for the skill check-off sheets to be maintained in the student record after the completion of class.
* Skill check-off sheets
  + The following information must be included:
    - Student name
    - Skill title per Appendix A in the state-approved curriculum
    - Skill number per Appendix A in the state-approved curriculum
    - Numbered steps needed to perform the skill
    - Blanks at each step to use for checkoff
    - Proficiency requirements including the number of required steps performed correctly, or starred critical steps, or both.
* Attendance records
  + Start date and end date of class
  + Training program number issued by the Division of Health Service Regulation
  + Instructor information (First and Last Name and RN Licensed Number)
* Missed instruction
* When – date of missed instruction
* How much time missed – hours/minutes
* What was missed – class (content), lab (demo, practice, checkoffs), and/or clinical (hours/minutes)
* What was assigned for makeup – worksheet, paper, lab (demo, practice, checkoffs) and/or hour-for-hour clinical
* When missed instruction was completed – completion date
* Test scores
* Tests and answer sheets
  + - Labeled with the version of test and the date given to students
    - Student identification
    - Copies of identifications or a student ID verification statement must be kept in each student record

*Important Notices:*

* Per [42 CFR §483.151](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.151), student records must be made available for review by the North Carolina Division of Health Service Regulation upon request
* Training programs are required to keep and maintain student records for a minimum of 3 years.
* Student records must be kept onsite, in a locked file cabinet, and in a locked area.

1. **Attendance:**

Successful completion of the training program is dependent upon the student completing a minimum of       clock hours (your total program hours minus the hours your program allows by policy for absences) of instruction.

All missed classroom, laboratory and clinical experiences must be completed in order for the student to successfully complete the training program and take the North Carolina State-approved competency evaluation.

*Important Notice*:

Please refer to the *Monitoring/Maintenance of Student Records* section within this document for more information*.*

1. **Documentation Required with the Submission of the Application**

* [Existing Training Program – Basic Equipment and Supply List](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) (Nurse Aide I Training Programs Only)
* Proprietary School – provide a copy of the current license and approval letter from the Office of Proprietary Schools

For program modifications, submit the applicable documents below.

* [Existing Training Program – Program](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) Modification Application
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Faculty Approval Request Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Faculty Removal Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Clinical Site Approval Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* [Existing Training Program – Clinical Site Removal Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)
* Classroom Diagram
* Laboratory Diagram

1. **Statement of Understanding:**

* I understand that 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. **Attestation:**  * I have read and agree to the Statement of Understanding. * I certify that the information in this application, and in the documentation submitted with the application, is truthful, accurate, and complete. * I certify that the information in this application, and in the documentation submitted with the application, accurately represents the 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.   **Program Administrator:**  First Name:  Last Name:  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (mm/dd/yyyy):  *Note: The North Carolina Division of Health Service Regulation will not accept an electronic signature. However, you may type your First Name, Last Name, and the Date.*  **Program Coordinator:**  First Name:  Last Name:  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (mm/dd/yyyy):  *Note: The North Carolina Division of Health Service Regulation will not accept an electronic signature. However, you may type your First Name, Last Name, and the Date.* |

**INSTRUCTIONS:**

Place an X beside the correct response (Yes or No) to indicate if the training program components are successfully being met.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Training Program Only:**  **Are You Meeting the**  **Program Component?** | **DHSR Only:**  **Is Training Program Meeting the**  **Program Component?** | **Program Component** | | | **DHSR Notes Only:** |
| Yes:  No: | Yes:  No: | 1. | The DHSR class schedule reflects each State Curriculum module letter and name with corresponding class hours, lab hours, and clinical hours. Totals for class hours, lab hours, and clinical hours are included and equal to State-approved totals.  (1 class hour of instruction is equal to 60 minutes) | |  |
| Yes:  No: | Yes:  No: | 2. | The schedule for each corresponding class roster is maintained. | |  |
| Yes:  No: | Yes:  No: | 3. | A minimum of 16 clock hours of training prior to any direct contact with a resident in the areas of communication and interpersonal skills; infection control; safety/emergency procedures, including the Heimlich maneuver; promoting residents’ rights independence; and respecting residents’ rights. | |  |
| Yes:  No: | Yes:  No: | 4. | Absences that occur during the defined areas of instruction listed in Item 3 above are made up prior to resident contact. | |  |
| Yes:  No: | Yes:  No: | 5. | Supplemental teaching methodologies are State-approved. | |  |
| Yes:  No: | Yes:  No: | 6. | Instructional resources, including primary textbook, are State-approved. | |  |
| Yes:  No: | Yes:  No: | 7. | Textbooks and audiovisuals are no more than 5 years old and meet current nursing practice standards. | |  |
| Yes:  No: | Yes:  No: | 8. | | The DHSR-approved minimum instructor/student ratios are maintained. |  |
| Yes:  No: | Yes:  No: | 9. | | Classroom and lab space and layout are State-approved. |  |
| Yes:  No: | Yes:  No: | 10. | | DHSR-approved equipment, materials and supplies are available and in working order. |  |
| Yes:  No: | Yes:  No: | 11. | | Faculty are State-approved. |  |
| Yes:  No: | Yes:  No: | 12. | | DHSR has been notified to remove past faculty from the program’s faculty list. |  |
| Yes:  No: | Yes:  No: | 13. | | State required faculty orientation and in-service activities are documented and available to DHSR upon request. |  |
| Yes:  No: | Yes:  No: | 14. | | Students are under the direct supervision of a DHSR-approved Registered Nurse while providing services to residents. |  |
| Yes:  No: | Yes:  No: | 15. | | Students perform only the services for which they have been trained and been found proficient by a DHSR-approved Registered Nurse instructor. |  |
| Yes:  No: | Yes:  No: | 16. | | All students wear nametags in clinical sites that include the word “trainee” or “student” after the student’s name. |  |
| Yes:  No: | Yes:  No: | 17. | | Documentation of student records monitoring is available to DHSR upon request. |  |
| Yes:  No: | Yes:  No: | 18. | | The Instructor ensures and maintains the integrity of the testing process. |  |
| Yes:  No: | Yes:  No: | 19. | | Student absences do not exceed program policy. |  |
| Yes:  No: | Yes:  No: | 20. | | The DHSR-approved method for determining theory, lab and clinical grades is followed including the proficiency policy. |  |
| Yes:  No: | Yes:  No: | 21. | | DHSR-approved passing grades for theory, lab and clinical are followed. |  |
| Yes:  No: | Yes:  No: | 22. | | Current clinical sites are DHSR-approved. |  |
| Yes:  No: | Yes:  No: | 23. | | Student records include the minimum required documents. |  |
| Yes:  No: | Yes:  No: | 24. | | Student records are maintained for at least three years. |  |
| Yes:  No: | Yes:  No: | 25. | | If a school has a State-approved Geriatric Aide Training Program, then the program requirements are being met. |  |
| Yes:  No: | Yes:  No: | 26. | | If a school has a State-approved Home Care Specialty Training for Nurse Aides Program, then the program requirements are being met. |  |
| Yes:  No: | Yes:  No: | 27. | | If a school has a State-approved Nurse Aide I Refresher Training Program, then the program requirements are being met. |  |