**PROGRAM ADJUSTMENT FORM – RESPONSE TO COVID-19**

**Effective Date: May 6, 2022**

**Instructions:**

* Email the completed form to the Division of Health Service Regulation (DHSR). Incomplete forms will be returned.
	+ Email: DHSR.EducationConsultant@dhhs.nc.gov
* Contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) with any questions or concerns.
* Click in the middle of each cell to begin entering information.

**Name of Training Program**:

**County Location of Training Program**:

**Name of Individual Who Completed the Form**:

**Date of Submission to DHSR**:

**Will Your Program Be Using a Healthcare Facility as a Clinical Site for Students Beginning on or after August 1, 2022?**

**Place an X Beside the Correct Response.**

**Yes**: **No**:

**If You Answered NO to the Question Above, Then Identify the DHSR Approved Clinical Sites Not Available to Your Students.**

1. Facility Name:       County:       Reason For Unavailability:
2. Facility Name:       County:       Reason For Unavailability:
3. Facility Name:       County:       Reason For Unavailability:
4. Facility Name:       County:       Reason For Unavailability:
5. Facility Name:       County:       Reason For Unavailability:
6. Facility Name:       County:       Reason For Unavailability:
7. Facility Name:       County:       Reason For Unavailability:
8. Facility Name:       County:       Reason For Unavailability:
9. Facility Name:       County:       Reason For Unavailability:
10. Facility Name:       County:       Reason For Unavailability:
11. Facility Name:       County :       Reason For Unavailability:
12. Facility Name:       County:       Reason For Unavailability:

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| **PROGRAM HOURS OVERVIEW** | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      |
| 1. Total number of approved program hours
 |       |       |       |       |       |       |       |       |       |       |
| 1. Number of approved classroom hours
 |       |       |       |       |       |       |       |       |       |       |
| 2.a Number of approved online hours if applicable |       |       |       |       |       |       |       |       |       |       |
| 1. Number of approved laboratory hours
 |       |       |       |       |       |       |       |       |       |       |
| 1. Number of approved clinical hours
 |       |       |       |       |       |       |       |       |       |       |

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| **ONLINE/REMOTE INSTRUCTION REQUEST** | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      |
| 1. Number of approved classroom hours
 |       |       |       |       |       |       |       |       |       |       |
| 1. Number of classroom hours requested for temporary transition to an online/remote format
 |       |       |       |       |       |       |       |       |       |       |
| 1. List of state-approved Nurse Aide I curriculum modules requested for transition to online/remote format
 |       |       |       |       |       |       |       |       |       |       |

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| CLINICAL HOURS REQUEST | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      | Program Number:      |
| 1. Total number of approved clinical hours
 |       |       |       |       |       |       |       |       |       |       |
| 1. Number of clinical hours requested in a laboratory setting
 |       |       |       |       |       |       |       |       |       |       |
| 1. List of skills to be performed in a laboratory setting in lieu of a healthcare facility
 |  Please complete the form titled, “COVID-19 Skills Form.”  |

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| IMPLEMENTATION OF COVID-19 GUIDANCE |
| How will the COVID-19 guidelines per CMS, CDC, NC, White House Recommendations, etc., be implemented? |       |

**I certify that the information submitted to DHSR is complete and accurate to the best of my knowledge.**

Name:

Title:

Signature:

Date (mm/dd/yyyy):

*An electronic (typed) signature* *is considered to be the legal signature for this document*

**DHSR STAFF ONLY:**

* Date received:
* Consultant:
* Decision:       Approved       Denied
* Decision date:
* Date decision communicated to program:
* Reason for denial:
* Comments: