**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:

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| **INSTRUCTIONS:**   * Complete the form if you are modifying program hours, the course schedule, or an instructional resource for an existing state-approved training program. * You may type your response in the space provided. * Utilize the North Carolina State-approved training curriculum. * Approval from the Division of Health Service Regulation (DHSR) is required prior to changes being implemented in the program. * The Program Coordinator must sign the document. * Email or fax completed documents to DHSR. Incomplete forms will be denied. You must submit all pages of this form for review.   + 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:Date Submitted to DHSR for Review (mm/dd/yyyy):  1. **Individual Completing Form:** 2. **Name of School:** 3. **Name of Training Program:** |
| 1. **Mailing Address:**  Street:City:Zip Code:County: |
| **6. Site Address:** Street:  * City: * Zip Code: * County:   **7. Program Coordinator:**   * Name: * E-mail: * Phone (including area code and extension):   **8. Program Modifications Type:**  Place an X beside the correct response. Select all that apply.   * Program Hours: * Course Schedule: * Supplemental Teaching Methodology:   **9. List the Applicable Program Number(s) Beside the Item(s) Below:**   * Nurse Aide I Training Program: * Nurse Aide I Refresher Training Program: * Geriatric Aide Training Program:  Home Care Aide Training Program: **10. Total Program Hours:**   * Classroom: * Laboratory: * Clinical: * Total Program Hours:   **11. Course Schedule Modification:**  The following information should be included on the form.   * Day:   + Use day number designations (Day 1, Day 2, Day 3). Do not use actual dates or include vacation dates or breaks (spring break or lunch).   + Programs may choose which day of the week a course begins.   + Each clinical day must be listed as a separate day. * Module Letter/Name:   + Enter each module letter and name. * Audiovisuals:   + List audiovisuals with run times.   + Run times should be included in the classroom program hours. * Program Hours:   + 1 hour = 60 minutes of instructions. Do not include breaks or mealtimes.   + Class: record the number of class theory hours required each day.   + Lab: record the number of lab hours spent in the laboratory each day.   + Clinical: record the number of hours spent in a clinical facility each day.   + Total hours must be calculated and documented at the end of each column.   + Class, lab, clinical & total hours must be the same as those listed on the program application.   **Course Schedule:** |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | | **Program Hours:** | | | | **Day** | **Module Letter and Name** | | **Include the Following Information:**  1. Appendix A Skill Number  2. Test/Quiz/Exam with Module Letters Tested and Reviewed  3. Other Class/Lab Activities | **Audiovisual Name and Run Time** | **Class**  **Hours** | **Lab Hours** | **Clinical Hours** | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  |  | |  |  |  |  |  | |  | | | | | **Program Hours:** | | | | **Day** | | **Module Letter and Name** | **Include the Following Information:**  1. Appendix A Skill Number  2. Test/Quiz/Exam with Module Letters Tested and Reviewed  3. Other Class/Lab Activities | **Audiovisual Name and Run Time** | **Class**  **Hours** | **Lab Hours** | **Clinical Hours** | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | |  |  |  |  |  |  | |  | | | | | | | | | **TOTAL PROGRAM HOURS** | | | | |  |  |  | |
| **12. Supplemental Teaching Methodology Modification:**  List additional proposed supplemental methodologies/strategies which may include, games, role-play, case studies, laboratory simulation, pamphlets, quick reference guides, etc.  Lecture, discussion, PowerPoint presentations, use of manikins, handouts, skills demonstration and clinical are teaching methodologies/strategies used in the applicable State-approved curriculums and do not need to be listed.   * Supplemental Teaching Methodology/Strategy: * Supplemental Teaching Methodology/Strategy: * Supplemental Teaching Methodology/Strategy: * Supplemental Teaching Methodology/Strategy:   Video/CD/DVD:   |  |  |  |  | | --- | --- | --- | --- | | **Name of Video/CD/DVD** | **Production Year** | **Name of Company** | **Run Time in Minutes** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   If any videos, CD’s, or DVD’s listed are older than five years, and have been reviewed to meet current nursing standards, then answer the question below to request permission to use as a resource.  Place an X beside the correct response.  I would like permission to use the videos, CD’s, and/or DVD’s.  Yes:       No:  Computer Assisted Instruction:   |  |  |  |  | | --- | --- | --- | --- | | **Name of Software** | **Production Year** | **Name of Company** | **Run Time in Minutes** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |   Textbook:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Name** | **Author** | **Publisher** | **Edition** | **Publication Year** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   Workbook:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Name** | **Author** | **Publisher** | **Edition** | **Publication Year** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  1. **Statement of Understanding:**   I certify that the information in the document, including additional forms and attachments, accurately represents the training program for which the North Carolina Division of Health Service Regulation approval is being requested.  I certify that the training program documents and student records will be kept in a secure location and made available to the North Carolina Division of Health Service Regulation upon request.  I certify that the training program will 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 state-approved Registered Nurse per federal regulation [42 CFR §483.152](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152).  I certify that the training program meets the requirements set forth by the State and/or federal rules, regulations and requirements. I understand that the North Carolina Division of Health Service Regulation may withdraw approval of the training program if it determines that the program does not meet federal or state regulations and requirements or does not adhere to the program information and documentation approved by the North Carolina Division of Health Service Regulation.  I understand that approval is based on our program using the most current version of the North Carolina state-approved curriculum.  I understand that modifications which are required by the North Carolina Division of Health Service Regulation will be incorporated into the training program in a timely manner.  I acknowledge and agree to the following:   * The information in this form is truthful, accurate and complete. * Implement the most current version of the North Carolina State-approved curriculum. * Establish and implement North Carolina Division of Health Service Regulation directives, policies, forms, and checklists as mandated by federal and state regulations and requirements. * The classroom will contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities. * Each laboratory will contain the items listed in the [New Training Program – Basic Equipment and Supply List](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) and will adhere to federal regulation [42 CFR §483.90](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.90). * Training objectives will be met through instructor demonstration, student practice and demonstration of proficiency.   **14. 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.  |  | | --- | | **Program Coordinator:**  Place an X beside the correct response.  I have read and agree to the Statement of Understanding and to the Electronic Signature Agreement.  Yes:       No: |   First and Last Name:  Signature:  Date (mm/dd/yyyy): |