**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 members of your state-approved training program faculty leave your school/facility or become inactive. One form must be completed for each faculty member. * You may type your response in the space provided. * The Program Coordinator or Program Administrator must sign the document. * Email or fax completed documents to the Division of Health Service Regulation (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:**   1. **Date Submitted to DHSR for Review (mm/dd/yyyy):** | | |
| 1. **Name of Training Program:** | | |
| 1. **Mailing Address:**  * Street: | | |
| * City: |  |  |
| * Zip Code: * County:  1. **Site Address:**  * Street: * City: * Zip Code: * County:  1. **Program Coordinator:**  * Name: | | |
| * Phone (include area code and extension): * Fax (include area code): | | |
| E-mail: | | |

# Date of Approval (mm/dd/yyyy):

1. **Faculty Position:**

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

* Program Coordinator and Instructor:
* Instructor:
* Program Coordinator:

**7. Identify the Applicable Training Programs:**

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

* Nurse Aide I Training Program:
* Nurse Aide I Refresher Training Program:
* Geriatric Aide Training Program:
* Home Care Aide Training Program:

**8. List the Applicable Training Program Number(s) for Program Coordinator:**

* Nurse Aide I Training Program Number(s):
* Nurse Aide I Refresher Training Program Number(s):
* Geriatric Aide Training Program Number(s):
* Home Care Aide Training Program Number(s):

**9. List the Applicable Training Program Number(s) for Instructor:**

* Nurse Aide I Training Program Number(s):
* Nurse Aide I Refresher Training Program Number(s):
* Geriatric Aide Training Program Number(s):
* Home Care Aide Training Program Number(s):

**10. Identify the Faculty Member:**

* First Name:
* Middle Name:
* Last Name:
* Registered Nurse License Number:

**11. Statement of Understanding:**

I certify that the information in the document accurately represents the training program approved by the Division of Health Service Regulation.

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 modifications which are required by the North Carolina Division of Health Service Regulation will be incorporated into the training program in a timely manner.

**12. 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 or Program Administrator:**

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

Title (Program Coordinator or Program Administrator):

Signature:

Date (mm/dd/yyyy):