**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 this form if your existing state-approved training program is seeking reapproval from the Division of Health Service Regulation (DHSR).
* A reapproval application must be completed for each training program number.
* You may type your response in the space provided.
* Approval from DHSR is required prior to changes being implemented in the training program.
* If you’re considering the transition of a classroom-based course to an online format, then please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) to determine if you meet the eligibility requirements and to determine the required documentation needed for approval.
* The Program Coordinator and Program Administrator must sign the application.
* Email or fax completed documents to DHSR. Incomplete forms will be denied. You must submit all pages of this document 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):** 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. **Administrative Authority:**  * Name: * Title: * Telephone (including area code): * Email:  1. **Program Coordinator:**  * Name: * Telephone (including area code and extension): * Email: * Fax (include area code):  1. **Identify the Applicable Training Program:**   Place an X beside the correct response.   * Nurse Aide I Training Program: * Nurse Aide I Refresher Training Program: * Geriatric Aide Training Program: * Home Care Aide Training Program: |
| 1. **Identify the Training Program Number:**   Important Notice:  A 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 all that apply.   * Continuing Education: * Curriculum: * Career and College Promise: |
| 1. **Proprietary Schools Only:**  |  | | --- | | * The license of this school for the current year is included with this application.   Place an X beside the correct response.  Yes:       No: | | * 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: |   **13. Current Program Hours:**   * Classroom Hours: * Online Hours (if applicable): * Laboratory Hours: * Clinical Hours: * Total Hours:   Important Notices:   * DHSR approval is required to change the number of classroom, online, laboratory, clinical and total hours. * You must receive DHSR approval prior to transitioning classroom program hours to an online format. Please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) to determine if you meet the eligibility requirements and to determine the required documentation needed for approval. |

1. **Current Instructor/Student Ratios:**

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

Important Notices:

* The instructor-to-student ratio for clinical cannot be greater than 1:10 per regulation [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).
* DHSR must approve each faculty member prior to instruction.

1. **Program Hours, Course Schedule or Supplemental Teaching Methodologies/Strategies:**

If you have not previously notified and received approval from DHSR regarding program modifications pertaining to program hours, course schedule or supplemental teaching methodologies/strategies, then please submit one of the following documents based on the most recent approval from DHSR.

* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Non-Hybrid Program)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html" \l "TP)
* [Existing Training Program – Course Schedule and Supplemental Teaching Methodology Form (Hybrid Program)](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)

Important Notices:

* Program modifications must be approved by DHSR prior to their implementation within a training program.
* If you’re considering the transition of a classroom-based course to an online format, then please contact your [Education Consultant](https://info.ncdhhs.gov/dhsr/hcpr/consultants.html) to determine if you meet the eligibility requirements and to determine the required documentation needed for approval.

1. **Faculty:**

Attached is a current list of approved faculty members. If you have not previously notified and received approval from DHSR regarding program modifications pertaining to faculty members, then please submit the following documents. The forms should be completed for each faculty member (as applicable).

* [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)

Important Notice:

Program modifications must be approved by DHSR prior to their implementation within a training program.

1. **Current State-Approved Classroom:**

* Facility name:
* Site address:
* Building name:
* Room number:

Important Notice:

Program modifications must be approved by DHSR prior to their implementation within a training program.

1. **Current State-Approved Laboratory:**

* Facility name:
* Site address:
* Building name:
* Room number:

Important Notice:

Program modifications must be approved by DHSR prior to their implementation within a training program.

1. **Clinical Site:**

If you have not previously notified and received approval from DHSR regarding program modifications pertaining to clinical sites, then please submit the following documents (as applicable).

* [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)

Important Notice:

Program modifications must be approved by DHSR prior to their implementation within a training program.

1. **Statement of Understanding:**

|  |
| --- |
| I certify that the information in this application, 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 training program approval is based on our agency using the most current version of the North Carolina state-approved curriculum.  I understand that the training program must adhere to the policies submitted and 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.  I understand that requests for training program modifications will be submitted to the North Carolina Division of Health Service Regulation for approval prior to implementation.  I understand that training program policies must be made available to the North Carolina Division of Health Service Regulation upon request. |
| I understand that the State 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 program refuses to permit unannounced visits by the State. |
| 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 [Existing Training Program – Basic Equipment and Supply List](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP). * Training objectives will be met through instructor demonstration, student practice and demonstration of proficiency  1. **Electronic Signature Agreement:**   You acknowledge and agree to the following statements:   * I certify that I have reviewed the entire application 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):

**Program Administrator:**

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):

**Continued Next Page**

**INSTRUCTIONS:**

Place an X beside the correct response (Yes or No) to indicate if each training program component is met.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Training Program Only:**  **Are You Meeting the**  **Program Component?** | **DHSR Only:**  **Is Training Program Meeting the**  **Program Component?** | **Program Components** | | | **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 program, the program requirements are followed. |  |
| Yes:  No: | Yes:  No: | 26. | | If a school has a State-approved Home Care Aide program, the program requirements are followed. |  |
| Yes:  No: | Yes:  No: | 27. | | If a school has a State-approved Nurse Aide I Refresher program, the program requirements are followed. |  |