**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 form if you are establishing a new state-approved training program.
* You may type your response in the space provided.
* Approval from the Division of Health Service Regulation (DHSR) is required prior to using a clinical site.
* 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
* 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. **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):
 |
| * E-mail:
 |

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. **Addition – Clinical Site #1**

|  |
| --- |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
 |
| * County:
1. **Addition – Clinical Site #2**
 |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
 |
| * County:
1. **Addition – Clinical Site #3**
 |
|  |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
 |

* County:
1. **Addition – Clinical Site #4**

|  |
| --- |
|  |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
 |

* County:
1. **Addition – Clinical Site #5**

|  |
| --- |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
* County:
 |
| 1. **Addition – Clinical Site #6**
 |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
* County:
 |

1. **Addition – Clinical Site #7**

|  |
| --- |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
* County:
 |
| 1. **Addition – Clinical Site #8**
 |
| Facility Identification (FID) Number:      (This can be found on the facility licensure certificate issued by DHSR)  |
| Name of Facility:        |
| Facility Phone Number (include area code):      Site Address: * Street:
 |
| * City:
 |
| * Zip Code:
* County:
 |
| 1. **Statement of Understanding:**

I certify that the information in the document 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 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.  |
| 1. **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.
 |
|  |

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| --- |
| **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):