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| **Instructions:**   * Complete the form if you are establishing a new training program. * Utilize the North Carolina State-approved training curriculum. * Receive approval from the Division of Health Service Regulation prior to implementing the course schedule and supplemental teaching methodologies. * Sign the document. An electronic signature will not be accepted. * Email or fax completed documents to the Division of Health Service Regulation. Incomplete forms will be returned.   + 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.  Date (mm/dd/yyyy): **Individual Completing Form:**  **Name of School:**  **Name of Training Program:** |
| **Mailing Address:** Street:City:Zip Code:County: |
| **Site Address:** Street:  * City: * Zip Code: * County:   **Program Coordinator:**   * Name: * E-mail: * Phone (including area code and extension):   I**dentify the Applicable Training Program(s):**  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: **Total Program Hours:**   * Classroom: * Online: * Laboratory: * Clinical:   Total Program Hours:  **Course Schedule:**  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). * Module Letter/Name:   + Enter each module letter and name. * Audiovisuals:   + List audiovisuals with run times. * Program Hours   + 1 hour = 60 minutes of instructions. Do not include breaks.   + Class: record the number of class theory hours required each day.   + Online: record the number of online hours required each week, if applicable.   + 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.   Note: Pages 2 through 4 apply to the Course Schedule. |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | | | | **Program Hours**  (Use Online Column if Applicable) | | | | | | **Day** | **Module Letter**  **and Name** | **Skill Number/**  **Appendix A** | **Audiovisual Name and Run Time** | **Class** | | **Online** | **Lab** | **Clinical** | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  | | | | **Program Hours**  (Use Online Column if Applicable) | | | | | | **Day** | **Module Letter**  **and Name** | **Skill Number/**  **Appendix A** | **Audiovisual Name and Run Time** | **Class** | | **Online** | **Lab** | **Clinical** | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  | | | | **Program Hours**  (Use Online Column if Applicable) | | | | | | **Day** | **Module Letter**  **and Name** | **Skill Number/**  **Appendix A** | **Audiovisual Name and Run Time** | **Class** | | **Online** | **Lab** | **Clinical** | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | |  |  |  |  |  | |  |  |  | | **Total Program Hours** | | | | |  |  |  |  | |
| **Supplemental Teaching Methodology:**  List additional proposed supplemental methodologies 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 used in the applicable State-approved curriculums and do not need to be listed.   * Supplemental Teaching Methodology: * Supplemental Teaching Methodology: * Supplemental Teaching Methodology: * Supplemental Teaching Methodology: * Supplemental Teaching Methodology: * Supplemental Teaching Methodology: * Supplemental Teaching Methodology:   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** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   **I certify that the information in this document is correct and accurate to the best of my knowledge.**  Name of Program Coordinator:  Signature of Program Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (mm/dd/yyyy): |