**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 establishing a new state-approved training program.
* You may type your response in the space provided.
* Review the [New Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP) to ensure faculty meet the required qualifications.
* Approval from the Division of Health Service Regulation (DHSR) is required prior to using faculty.
* The Registered Nurse and Program Coordinator or Program Administrator 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:**1. **Date Submitted to DHSR for Review (mm/dd/yyyy):**
 |
| 1. **Name of School:**
2. **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:
* Program Coordinator:
* Instructor:
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. **Applicant Requirements:**

Place an X beside the correct response.

Does the applicant meet the requirements outlined in the [New Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP)?

Yes:       No:

1. **Applicant/Faculty Name that Appears on the Registered Nurse License:**
* First Name:
* Middle Name:
* Last Name:

|  |
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| * For Program Coordinator, please provide email address:
1. **Original Registered Nurse Licensure Information:**
* State Where Original Registered Nurse Licensure Issued:
* Date Original Registered Nurse Licensure Issued (mm/dd/yyyy):
* Name of College/University/School of Nursing:
* Mailing Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Graduation Year:
1. **North Carolina Board of Nursing (NCBON) Licensure Information:**
* License Number from the NCBON Website:
* Date Registered Nurse License Issued (mm/dd/yyyy):
* License Expiration Date (mm/dd/yyyy):
* Is the License Unencumbered?

Place an X beside the correct response.Yes:       No:      * Is the License Permanent or Temporary?

Place an X beside the correct response.Permanent:       or Temporary:      * NCBON Website Verification Number:
	+ Important Notice: Attach the verification form to this application.
1. **Compact State Registered Nurse Licensure Information:**
* State Where Registered Nurse License Issued:
* Compact State Registered Nurse License Number:
* Date Registered Nurse License Issued (mm/dd/yyyy):
* License Expiration Date (mm/dd/yyyy):
* Is the License Unencumbered?

Place an X beside the correct response.Yes:       No:      * Is the License Permanent or Temporary?

Place an X beside the correct response.Permanent:       or Temporary:      1. **Other Active State Registered Nurse Licensure Information:**
* State where Registered Nurse License Issued:
* Other Active State Registered Nurse License Number:
* Date Registered Nurse License Issued (mm/dd/yyyy):
* License Expiration Date (mm/dd/yyyy):
* Is the License Unencumbered?

Place an X beside the correct response. Yes:       No:      * Is the License Permanent or Temporary?

Place an X beside the correct response.Permanent:       or Temporary:       |
| 1. **Instructors Currently Approved at a North Carolina State-Approved Nurse Aide I Training Programs:**

Place an X beside the correct response.Is the Registered Nurse currently approved as an instructor at a North Carolina state-approved Nurse Aide I training program? Yes:       No:      If **No or applying as a Program Coordinator**, please complete the employment history, teaching experience and teaching methodology course information in the document below. If applying as a Program Coordinator, indicate your long-term care experience that corresponds with the [New Training Program – Faculty Approval Requirements Form](https://info.ncdhhs.gov/dhsr/hcpr/nat.html#TP). If **Yes**, please list the program name and approval date for each state-approved training program.  |
| * Program Name:

Approval Date (mm/yyyy):        |
| * Program Name:

Approval Date (mm/yyyy):        |

1. **Registered Nurse Experience that Demonstrates Requirements:**

If you are currently employed as an instructor at a North Carolina state-approved Nurse Aide I training program, then you are not required to complete the following sections below:

* Registered Nurse Employment History
* Adult Teaching Experience
* Teaching Methodology Course/Workshop

Important Notice:

The Applicant/Registered Nurse and Program Coordinator or Program Administrator are required to sign the document on the last page of the form.

1. **Registered Nurse Employment History #1:**
* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Facility Name:
* Position:
* Site Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Phone (include area code):
* Did You Work Full Time?

Place an X beside the correct response.

Yes:       No:

If you worked part time, include the number of hours worked each week:

* Type of Facility:

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

* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:

* Swing Bed Unit:
* Supervised Nurse Aides as Part of the Job:
* Cared for Chronically Ill or Elderly:
* Other Please Specify:

1. **Registered Nurse Employment History #2:**
* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Facility Name:
* Position:
* Site Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Phone (include area code):
* Did You Work Full Time?

Place an X beside the correct response.

Yes:       No:

If you worked part time, include the number of hours worked each week:

* Type of Facility:

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

* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Supervised Nurse Aides as Part of the Job:
* Cared for Chronically Ill or Elderly:
* Other Please Specify:
1. **Registered Nurse Employment History #3:**
* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Facility Name:
* Position:
* Site Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
* Phone (include area code):
* Did You Work Full Time?

Place an X beside the correct response.

Yes:       No:

If you worked part time, include the number of hours worked each week:

* Type of Facility:

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

* Nursing Home:
* Hospital Skilled Nursing Facility:
* Intermediate Care Facilities - Individuals with Intellectual Disabilities (ICF/IID):
* Medical/Surgical:
* Home Care:
* Home Health:
* Hospice:
* Swing Bed Unit:
* Supervised Nurse Aides as Part of the Job:
* Cared for Chronically Ill or Elderly:
* Other Please Specify:
1. **Experience Teaching Adults #1:**
* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Facility Name:
* Site Address:
* Street:
* City:
* State:
* Zip Code:
* Phone (include area code):
* Describe Experience:
1. **Experience Teaching Adults #2:**
* Date From (mm/yyyy):
* Date To (mm/yyyy):
* Facility Name:
* Site Address:
* Street:
* City:
* State:
* Zip Code:
* Phone (include area code):
* Describe Experience:
1. **Teaching Methodology Course/Workshop:**
* Name of Course/Workshop:
* Sponsored By:
* Mailing Address:
	+ Street:
	+ City:
	+ State:
	+ Zip Code:
	+ Date Completed (mm/dd/yyyy):
	+ Course Content:
1. **Statement of Understanding:**

I certify that the information in this form, including additional forms and attachments, accurately represents the Nurse Aide I 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 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 acknowledge and agree to the following:

* The information in this form is truthful, accurate and complete.
* The minimum requirements for the requested position are met.
* 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.
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.

**Applicant/Registered Nurse:**

|  |
| --- |
| 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 Coordinator or Program Administrator:**

|  |
| --- |
| 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):