2709 Mail Service Center
Raleigh, NC 27699-2709
Division of Health Service Regulation

**Health Care Personnel Education and Credentialing Section**

Phone: 919-855-3970
Fax: 919-733-9764
N.C. Department of Health and Human Services

# NURSE AIDE I TRAINING FACULTY REQUIREMENTS WORKSHEET

All Nurse Aide I Training Faculty must meet the requirements as specified below. Please use this worksheet to evaluate potential faculty. Complete a **Faculty Approval Request Form** for each member of your nurse aide faculty. Complete the **Faculty Approval Request Form** by including information that demonstrates the requirements below. This form can be found on our website: www.ncnar.org.

***DO NOT RETURN THIS WORKSHEET WITH THE FACULTY APPROVAL REQUEST FORM***

## PROGRAM COORDINATOR

| MEETS (✓) | REQUIREMENTS |
|---|---|
| | 1. The applicant is a registered nurse with an unencumbered license. |
| | 2. The applicant is licensed to practice in North Carolina. |
| | 3. The applicant has at least two (2) years (4000 hours) of experience as a registered nurse in the United States. |
| | 4. The applicant has at least one (1) year (2000 hours) of RN experience in the provision of long-term care facility services in the United States demonstrated by:<br>a. working in a long-term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital, **or**<br>b. supervising or teaching students in a long-term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital. |

## INSTRUCTOR

| MEETS (✓) | REQUIREMENTS |
|---|---|
| | 1. The applicant is a registered nurse with an unencumbered license. |
| | 2. The applicant is licensed to practice in North Carolina. |
| | 3. The applicant has at least two (2) years (4000 hours) of experience as a registered nurse in the United States. |
| | 4. The applicant meets at least **one** of the following:<br>a. completion of a course in teaching adults,<br>b. experience in teaching adults, or<br>c. experience in supervising nurse aides. |

# FACULTY APPROVAL REQUEST FORM
## North Carolina Division of Health Service Regulation

***Please use this form as a template to make additional copies. Any time you add faculty, a new form must be completed and submitted to DHSR for approval. To remove faculty, please use the Faculty Removal Form (www.ncnar.org).***

| | | |
|---|---|---|
| School/Facility: | | |
| Mailing Address: | | |
| City: | County: | Zip Code: |
| Program Coordinator's Area Code/Phone #: | | Direct Extension: |
| Area Code/Fax Line #: | Program Coordinator's E-mail Address: | |
| Enter All Applicable Program Numbers Below | | |
| Nurse Aide I Program Number(s): | Geriatric Aide Program Number(s): | |
| Refresher Course Program Number(s): | Home Care Aide Program Number(s): (Refer to Page 2 of Home Care Aide program application) | |

| ✓ | **Position(s) Requested** (Please check all boxes that apply) | **Applicant's Name as it appears on RN License** (Please Print Name) |
|---|---|---|
| | | |
| | Program Coordinator for NAT | First: |
| | Program Coordinator for Refresher | Middle: |
| | Instructor | Last: |

| | | |
|---|---|---|
| RN License #: _____ | ☐ N.C. License OR<br>☐ Compact State License: Which state? _____ | ☐ Other state license: _____ |
| ☐ Permanent or ☐ Temporary<br>(*Note: If temporary NC RN # is assigned, DHSR must be notified when permanent NC RN license # is issued) | License Expiration Date: _____ | License is free from Charges/Discipline Against: ☐ Yes ☐ No |
| Date of Original RN Licensure (Month/Year): | State of Original Licensure: | |
| N.C. Board of Nursing Confirmation #_____ Date: _____ | | |

I certify that the information in this application is correct and accurate to the best of my knowledge and that the minimum requirements for the position(s) requested have been met.

Signature: _____ Date: _____
Applicant

Signature: _____ Date: _____
Nurse Aide I Program Coordinator/Administrator/Director of Nursing

Printed: _____
Nurse Aide I Program Coordinator/Administrator/Director of Nursing

A Program Coordinator or RN Administrator/Owner signature is required for all proprietary schools.

Signature: _____ Date: _____

**Name of Applicant:** _____

**I. BASIC NURSING EDUCATION**

| |
|---|
| Name of College/University/School of Nursing: |
| Street Address: |
| City/State/Zip Code: |
| Indicate Highest Nursing Educational Level: ☐ ADN ☐ Diploma ☐ BS ☐ MSN ☐ Other |

**II. OTHER EDUCATION**

| | |
|---|---|
| College/University: | |
| Discipline: | Degree: |

**PLEASE INCLUDE RN EXPERIENCE THAT DEMONSTRATE REQUIREMENTS ONLY**

**III. REGISTERED NURSING EMPLOYMENT HISTORY**

| | | | | |
|---|---|---|---|---|
| Dates: From: | | | To: | |
| ( Month/Day/Year) | | | (Month/Day/Year) | |
| Facility: | | | Position: | |
| Type of Facility: | | | ☐ Full time | |
| Address: | | | ☐ Part time: _____ (# of hours/week) | |
| City/State/Zip: | | | | |
| Area Code/Phone: | | | | |
| **Check all boxes that apply to this experience:** | | | | |
| ☐ Nursing Home | ☐ ICF/MR | ☐ Med/Surg | ☐ Hospital SNF | ☐ Home Care/Home Health/Hospice |
| ☐ Swing Bed Unit | ☐ Supervised NAs as part of job | | ☐ Cared for chronically ill or elderly | |
| ☐ Other (specify) | | | | |

| | | | | |
|---|---|---|---|---|
| Dates: From: | | | To: | |
| (Month/Day/Year) | | | (Month/Day/Year) | |
| Facility: | | | Position: | |
| Type of Facility: | | | ☐ Full time | |
| Address: | | | ☐ Part time: _____ (# of hours/week) | |
| City/State/Zip: | | | | |
| Area Code/Phone: | | | | |
| **Check all boxes that apply to this experience:** | | | | |
| ☐ Nursing Home | ☐ ICF/MR | ☐ Med/Surg | ☐ Hospital SNF | ☐ Home Care/Home Health/Hospice |
| ☐ Swing Bed Unit | ☐ Supervised NAs as part of job | | ☐ Cared for chronically ill or elderly | |
| ☐ Other (specify) | | | | |

**Name of Applicant:** _____

**III. REGISTERED NURSING EMPLOYMENT HISTORY CON'T.**

| Dates: From: | To: |
|---|---|
| ( Month/Day/Year) | (Month/Day/Year) |
| Facility: | Position: |
| Type of Facility: | ☐ Full time |
| Address: | ☐ Part time: _____ (# of hours/week) |
| City/State/Zip: | |
| Area Code/Phone: | |

**Check all boxes that apply to this experience:**

| | | | | |
|---|---|---|---|---|
| ☐ Nursing Home | ☐ ICF/MR | ☐ Med/Surg | ☐ Hospital SNF | ☐ Home Care/Home Health/Hospice |
| ☐ Swing Bed Unit | ☐ Supervised NAs as part of job | | ☐ Cared for chronically ill or elderly | |
| ☐ Other (specify) | | | | |

**IV. ADULT TEACHING EXPERIENCE**

| Dates: From: | To: |
|---|---|
| (Month/Day/Year) | (Month/Day/Year) |
| Facility: | Describe teaching experience: |
| Address: | |
| City/State/Zip: | |
| Area Code/Phone: | |

| Dates: From: | To: |
|---|---|
| (Month/Day/Year) | (Month/Day/Year) |
| Facility: | Describe teaching experience: |
| Address: | |
| City/State/Zip: | |
| Area Code/Phone: | |

**V. TEACHING METHODOLOGY COURSE**

| Sponsored by: | |
|---|---|
| Address: | |
| Course content: | Date completed: |

**VI. ADDITIONAL INFORMATION YOU MAY WANT CONSIDERED RELATED TO THE REQUIREMENTS:**

**Complete and fax <u>each</u> form separately to 919-733-9764.**