



Janice K. Brewer
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing

Application for Additional Site Existing Consolidated NA Training Program

PROGRAM INFORMATION

Name of NA Training Program

Name of Coordinator/Contact Person

Address		City	State	Zip
Telephone #	Fax #	Email Address		Website

TYPE OF PROGRAM

- | | | |
|---|--|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> High School | <input type="checkbox"/> Private School |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Community College | <input type="checkbox"/> Skill Center |
| | <input type="checkbox"/> University | <input type="checkbox"/> Other _____ |

Long-term care facilities or nursing homes can not become consolidated programs as they maintain separate licenses issued by the Department of Health Services and are subject to state and federal sanction.

OFFICIAL USE ONLY	
Recommendation to Executive Director	
Signature – Education Consultant	Date
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Comments:	
Signature - Executive Director	Date Approved or Denied

PROGRAMS MUST MEET THE FOLLOWING CRITERIA TO RECEIVE APPROVAL FOR CONSOLIDATION

- The new site is part of the same department on the organizational chart;
- A single RN administrator or coordinator has authority and responsibility for all sites, instructors and the coordinator, if the administrator is not the coordinator and has a major role in hiring, retention and evaluation of all instructors;
- Curriculum and policies are identical for all sites;
- The hour-for-hour breakdown for didactic, laboratory, and clinical are identical for all sites;
- The sites are comparable in terms of classroom, lab facilities and supplies; and
- Student records for this site will be stored in a central location with all other records.

PROGRAM PERSONNEL

ADMINISTRATOR

Name	Telephone #

COORDINATOR

R4-19-801-©(1)(a) states: A program coordinator shall hold a current, registered nurse license that is active and in good standing under A.R.S. Title 32, Chapter 15. R4-19-801-(C)(1)(b) states: A program coordinator shall possess at least 2 years of nursing experience at least one of which is in the provision of long-term care facility services. Document experience in the space provided below.

Name (as it appears on license)	RN License #

AGENCY NAME/LOCATION	POSITION	CLINICAL AREA	FROM MONTH/YEAR	TO MONTH/YEAR

INSTRUCTOR

R4-19-801-I(4)(a) states: A program instructor shall hold a current, registered nurse license that is active and in good standing under A.R.S. Title 32, Chapter 15. R4-19-801-(C)(4)(b) states: A program instructor shall possess one or more of the following: credit for a course on teaching adults; one year of experience teaching adults; or one year of experience supervising nursing assistants.

Please provide the following information for **each** instructor for the proposed sites listed below.

Name (as it appears on license)	RN License #

R4-19-801-I(4)(b) states: A program instructor shall possess ONE OR MORE OF THE FOLLOWING:				
R4-19-801-I(4)(b)(i) Credit for a course on teaching adults	COLLEGE~UNIVERSITY~INSITITUTION LOCATION	COURSE TITLE	CREDITS	DATE COMPLETED
R4-19-801-©(4)(b)(ii): One year of experience teaching adults	COLLEGE~UNIVERSITY~FACILITY LOCATION	COURSE CONTENT	FROM MONTH/YEAR	TO MONTH/YEAR
R4-19-801-©(4)(b)(iii): One year of experience supervising nursing assistants.	FACILITY~LOCATION	POSITION~CLINICAL AREA	FROM MONTH/YEAR	TO MONTH/YEAR

USE ADDITIONAL PAGE(S) IF NECESSARY

PROPOSED SITE(S)

A copy of the clinical contract between the primary approval site and the new clinical training site(s) must accompany this application.

Name of Site	Telephone #	Fax #	
Address	City	State	Zip

List Site Instructors

Name Agency to be used for Clinicals	<input type="checkbox"/> Hospital	<input type="checkbox"/> Home Health Agency
	<input type="checkbox"/> Nursing Facility Medicare Certified	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Site	Telephone #	Fax #	
Address	City	State	Zip

List Site Instructors

Name of Agency to be used for Clinicals	<input type="checkbox"/> Hospital	<input type="checkbox"/> Home Health Agency
	<input type="checkbox"/> Nursing Facility Medicare Certified	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Site	Telephone #	Fax #	
Address	City	State	Zip

List Site Instructors

Name of Agency to be used for Clinicals	<input type="checkbox"/> Hospital	<input type="checkbox"/> Home Health Agency
	<input type="checkbox"/> Nursing Facility Medicare Certified	<input type="checkbox"/> Yes <input type="checkbox"/> No

USE ADDITIONAL PAGE(S) FOR PROPOSED SITE(S) IF NECESSARY

VERIFICATION

The undersigned verifies that the information provided in this application is true and correct in every respect and agrees to apply to the Board 30 days before a new site is added to the program.

Signature of NA Training Program Administrator or Coordinator

Date