

Janice K. Brewer
Governor



Joey Ridenour
Executive Director

Arizona State Board of Nursing

Nursing Assistant Training Program Application for Site Consolidation for an Existing 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.

PROGRAMS MUST MEET THE FOLLOWING CRITERIA TO RECEIVE APPROVAL FOR CONSOLIDATION

- The programs to be consolidated are in the same department on the organizational chart; Yes No
- 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; Yes No
- Curriculum and policies are identical for all sites; Yes No
- The hour-for-hour breakdown for didactic, laboratory, and clinical are identical for all sites; Yes No
- The sites are comparable in terms of classroom, lab facilities and supplies; and Yes No
- Student records for this site will be stored in a central location with all other records. Yes No

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

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

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.

Name (as it appears on license)	RN License #

R4-19-801-I(4)(b) states: A program instructor shall possess <u>ONE OR MORE OF THE FOLLOWING:</u>				
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 SITES

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) IF NECESSARY

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
--------------------------------	-------------------------