

PROGRAM PERSONNEL

ADMINISTRATOR - OWNER

Name:	Telephone:
	Email:

COORDINATOR R4-19-802(B)(1); R4-19-802(B)(3)

Program coordinator qualifications include: a. Holding a current, registered nurse license that is active and in good standing or multistate privilege to practice as an RN under A.R.S. Title 32, Chapter 15; and b. Possessing at least two years of nursing experience at least one year of which is in the provision of long-term care facility services. A program coordinator's responsibilities include: a. Supervising and evaluating the program; b. Ensuring that instructors meet Board qualifications and there are sufficient instructors to provide for a clinical ratio not to exceed 10 students per instructor; c. Ensuring that the program meets the requirements of this Article; and d. Ensuring that the program meets federal requirements regarding clinical facilities under 42 CFR 483.151.

Name (as it appears on license):	RN License #
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Telephone:	Email:
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Agency Name/Location	Position	Clinical Area	From Month/Year to Month/Year:

INSTRUCTOR R4-19-802(C)(1)

Program instructor qualifications include: a. Holding a current, registered nurse license that is active and in good standing under A.R.S. Title 32, Chapter 15 and provide documentation of a minimum of one year full time or 1500 hours employment providing direct care as a registered nurse in any setting; and b. At a minimum, one of the following: i. Successful completion of a three semester credit course on adult teaching and learning concepts offered by an accredited post-secondary educational institution, ii. Completion of a 40 hour continuing education program in adult teaching and learning concepts that was awarded continuing education credit by an accredited organization, iii. One year of full-time or 1500 hours experience teaching adults as a faculty member or clinical educator, or iv. One year of full time or 1500 hours experience supervising nursing assistants, either in addition to or concurrent with the one year of experience required in subsection (C)(1)(a).

Please provide the following information for each instructor.

Name (as it appears on license):	RN License #:
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Telephone:	Email:
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Instructor has had 1500 hours or one year full time employment as an RN providing direct care (R4-19-802(C)(1)) Yes No

Location:	Job Title:	From Month/Year to Month/Year:
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Location:	Job Title:	From Month/Year to Month/Year:
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R4-19-802 (C)(1)(b)(i) Successful completion of a three semester credit course on adult teaching and learning concepts offered by an accredited post-secondary educational institution

COLLEGE~UNIVERSITY~INSITITUTION LOCATION	COURSE TITLE	CREDITS	DATE COMPLETED

R4-19-802 (C)(1)(b)(iii) One year of full-time or 1500 hours experience teaching adults as a faculty member or clinical educator

COLLEGE~UNIVERSITY~INSITITUTION LOCATION	COURSE TAUGHT	FROM MONTH/YEAR to MONTH/YEAR

R4-19-802 (C)(1)(b)(iv) One year of full time or 1500 hours experience supervising nursing assistants, either in addition to or concurrent with the one year of experience required in subsection C)(1)(a)

FACILITY~LOCATION	POSITION~CLINICAL AREA	FROM MONTH/YEAR to MONTH/YEAR

USE ADDITIONAL PAGES IF NECESSARY

CLINICAL AGENCIES

This section is to be completed by schools and independent programs. Copies of cooperating agency agreements must be included in your application and remain on file with the Arizona State Board of Nursing.

Name of Agency:	Telephone:	Fax:
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Type of Agency:
 Nursing Facility Hospital Medicare Certification Status _____ Other

Name of Contact Person:

Facility Address:	City:	State:	Zipcode:
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CLINICAL AGENCIES

Name of Agency:	Telephone:	Fax:
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Type of Agency:
 Nursing Facility Hospital Medicare Certification Status _____ Other

Name of Contact Person:

Facility Address:	City:	State:	Zipcode:
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CLINICAL AGENCIES

Name of Agency:	Telephone:	Fax:
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Type of Agency:
 Nursing Facility Hospital Medicare Certification Status _____ Other

Name of Contact Person:

Facility Address:	City:	State:	Zipcode:
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CLINICAL AGENCIES

Name of Agency:	Telephone:	Fax:
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Type of Agency:
 Nursing Facility Hospital Medicare Certification Status _____ Other

Name of Contact Person:

Facility Address:	City:	State:	Zipcode:
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CLINICAL AGENCIES

USE ADDITIONAL PAGES IF NECESSARY