



APPLICATION FOR APPROVAL OF TRAINING COURSE

Course Type (please check one):

- 2008 90-Hour CNA CNA Refresher Course 75-Hour CMA** 20-Hour HHA**
- OTA/PTA Bridge 30-Hour Bridge CMA Continuing Education

** Students must pass an 8th grade reading level and comprehension test before enrolling in these courses.

NOTE: Please consult appropriate **Instructor manual** for guidelines on filling out this application.

This application MUST be received by this office THREE WEEKS (21 days) prior to the beginning date of the course. If not, the application will be returned so that the dates of the course can be adjusted to meet the three week requirement. If a request for waiver is included, both the application and the waiver MUST be received by this office FOUR WEEKS (28 days) prior to the course start date.

■Date Application Submitted _____ / _____ / _____ ■Date received by HOC _____ / _____ / _____

■Course Begins _____ / _____ / _____ ■Course Ends _____ / _____ / _____

■Primary Instructor Name _____ Instructor's ID# _____

■ Current Address: _____
Street City Zip

■ Current Phone Number: (_____) _____ E-Mail address: _____

■KS RN License # _____ / _____ / _____ KS RN Licensure Expiration Date _____ / _____

■Sponsoring Facility/School _____ ■KS Facility/School ID# _____

■Coordinator Name _____ Phone # (_____) _____

■Address _____
Street and/or PO Box City State Zip

■Clinical Site _____ ■KS Facility ID# _____

■Address _____
Street and/or PO Box City State Zip

■Classroom Site _____
Address City

■Class Days & Times: _____

■Course Training Includes:

	PART 1 (If applicable)	PART 2 (If applicable)	TOTAL HOURS
CLASS HOURS			
LAB/CLINICAL HOURS			
TOTAL HOURS			

Please adapt the grid to the type of course given. For courses which do not have two parts, use the "TOTAL HOURS" column to enter the number of hours. Be prepared to present course schedule (topics, times and dates) on request.

DEPARTMENT USE

■Course # _____ ■Approval Date ____ - ____ - ____ ■Disapproval Date ____ - ____ - ____

■Reviewer's Signature _____ ■Date _____

Reason for Disapproval:

Please attest that the following information about the course you intend to conduct is true:

ALL AIDE COURSES

- yes 1. I have read and will follow the applicable regulations, curriculum guidelines and instructor manual in preparation for this course.
- yes 2. The primary text for this course will be the Kansas approved curriculum guidelines, if applicable. The 2008 Kansas approved curriculum guidelines will be used for all CNA courses. The 2003 approved curriculum will be used for all CMA courses. The 2005 approved curriculum will be used for all HHA courses. A secondary text is optional. If a student text or workbook is used, please note the author/s, title, edition and publisher here:
- yes 3. I will assure an adequate environment for the course, i.e., adequacy of classroom, availability of equipment, etc.
- yes 4. I will provide in writing to all students on the first day of class, the methods of student evaluation/grading including attendance requirements for classroom, clinical and makeup.
- yes 5. I will provide a program and instructor evaluation to the students which will be used to evaluate the success of this course.
- yes 6. During class or clinical instruction, the instructor will perform no other duties but the supervision of the trainees. The person designated to assume the instructor's regular staff duties during this time is: _____.
- yes 7. I will inform both instructor and students of the state agency's phone number for registering complaints: (785) 296-6796.
- yes 8. I will notify KDHE **prior** to any changes or cancellations being made to the course.
- yes 9. I understand that additional information may be requested by the department to verify requirements have been met, and that the department may make unannounced onsite visits. I will keep a copy of the course schedule available at the training site.
- yes 10. I understand that this application must be received by Health Occupations Credentialing (HOC) at least three weeks (21 days) prior to the start date of the class. If a request for waiver is included, both must be received by HOC four weeks (28 days) before the course start date. All late applications will be returned.
- yes 11. I understand that no nurse aide who is employed by, or who has received an offer of employment from, a Medicare/Medicaid facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials). CFR 483.152(c)(1)

CNA COURSE

- yes 1. The task checklist and Paid Nutrition Assistant certificate will be given to successful students at the conclusion of Part I.

CMA COURSE and 20-HR HHA COURSE,

Which method of prescreening and testing will be utilized for students intending to take this course?

CASAS Other (specify standardized test) _____

- yes 1. I have verified with the Kansas Board of Regents that the test version used will test reading and comprehension at an eighth grade level.

CMA CONTINUING EDUCATION COURSE ONLY:

- yes 1. The course will include a minimum of 10 hours of instruction in any or all of the following topics:
- a. New classes of drugs and new drugs
 - b. New uses of drugs
 - c. New methods of administering drugs
 - d. Alternative treatments such as herbs, acupuncture, interaction with traditional drugs
 - e. Safety and administration of drugs
 - f. Documentation

CNA REFRESHER COURSE ONLY:

- yes 1. The course will include a minimum of five hours of didactic and five hours of lab or clinical experience.
- yes 2. The course will include didactic instruction on each of the following 10 topics and will also include lab or clinical instruction for items #4 through #7.
- 1. The CNA's Responsibility in health care delivery
 - 2. Meeting Resident Needs: Communication
 - 3. Meeting Resident Needs: Resident Rights, including issues involving Abuse, Neglect and Exploitation, and culture change.
 - 4. Meeting Resident Needs: Safety, including the Heimlich maneuver.
 - 5. Meeting Resident Needs: Infection Control, including handwashing
 - 6. Meeting Resident Needs: Basic nursing skills, including measurement and recording of vital signs
 - 7. Meeting Resident Needs: Personal care skills, including feeding, bathing, dressing, elimination needs, skin care; transfers: positioning and turning.
 - 8. Meeting Resident Needs: End of life care
 - 9. Meeting Resident Needs: Care of the cognitively impaired resident
 - 10. Meeting Resident Needs: Basic restorative services

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments.

Coordinator Signature

Instructor Signature

ADDITIONAL INFORMATION

Is this course a Distance Learning Network, Interactive Network or similar type course? Yes No

Please list additional instructors, classroom and clinical sites here.

■ **Instructor Name** _____ Instructor's ID# _____

■ KS RN License # _____ / _____ / _____ KS RN Licensure Expiration Date _____ / _____

■ Current Address: _____
Street City Zip

Current Phone # () _____ E-Mail Address: _____

■ **Instructor Name** _____ Instructor's ID# _____

■ KS RN License # _____ / _____ / _____ KS RN Licensure Expiration Date _____ / _____

■ Current Address: _____
Street City Zip

■ Current Phone # () _____ E-Mail Address: _____

■ **Instructor Name** _____ Instructor's ID# _____

■ Current Address: _____
Street City Zip

■ KS RN License # _____ / _____ / _____ KS RN Licensure Expiration Date _____ / _____

■ Current Phone # () _____ E-Mail Address: _____

■ **Instructor Name** _____ Instructor's ID# _____

■ Current Address: _____
Street City Zip

■ KS RN License # _____ / _____ / _____ KS RN Licensure Expiration Date _____ / _____

■ Current Phone # () _____ E-Mail Address: _____

■ **Classroom Site** _____ ■ KS Facility ID# _____

■ Address _____
Street and/or PO Box City State Zip

■ **Classroom Site** _____ ■ KS Facility ID# _____

■ Address _____
Street and/or PO Box City State Zip

■ **Classroom Site** _____ ■ KS Facility ID# _____

■ Address _____
Street and/or PO Box City State Zip

■ **Clinical Site** _____ ■ KS Facility ID# _____

■ Address _____
Street and/or PO Box City State Zip

■ **Clinical Site** _____ ■ KS Facility ID# _____

■ Address _____
Street and/or PO Box City State Zip

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■ Address _____
Street and/or PO Box City State Zip