



**Employment Information (Licensed Nursing Experience)**

Please provide only the employment information on the following pages that directly demonstrates that you meet the instructor qualifications previously described. If additional space is needed, please follow the same format as this form. A resume may not be substituted for the information requested in this section.

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _____ To: _____ mm / dd / yr mm / dd / yr		
Hours Per Week		

If you supervised employees please indicate the number and type of work they did. Number of aides \_\_\_\_\_  
Type of Work \_\_\_\_\_ Dispensed Medication \_\_\_\_\_

**Employment Verification Attached** \_\_\_\_\_

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _____ To: _____ mm / dd / yr mm / dd / yr		
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Type of Work \_\_\_\_\_ Dispensed Medication \_\_\_\_\_

**Employment Verification Attached** \_\_\_\_\_

**Adult Education Training Course**

Training School Name	TRAINING COURSE IN ADULT EDUCATION OR A PROFESSIONAL CONTINUING EDUCATION COURSE ON SUPERVISION OR ADULT EDUCATION MAY BE DOCUMENTED BY SUBMISSION OF POST-SECONDARY TRANSCRIPT OR CERTIFICATE OF COMPLETION.
School Mailing Address	
Dates of Attendance  From: _____ To: _____ mm/dd/yy mm/dd/yy	

**NOTE:** Course instructors and sponsors are responsible for being knowledgeable of and adhering to all pertinent statutes, regulations, policies or administrative guidelines in making application for course approval including but not limited to Kansas Statutes Annotated 39-926, Kansas Administrative Regulations 28-39-165 through 170, the Kansas 90-Hour Nurse Aide, Home Health Aide, or Medication Aide Curriculum Guidelines.

**Signature of Applicant:** 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. I do hereby acknowledge that it is my responsibility to obtain employment verification from current/previous employer(s) for each reference listed on the application. I am fully aware that failure to provide this information to Health Occupations Credentialing will delay the processing of this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete all the employment information that demonstrates that you meet the instructor qualifications and attach the employment verification forms which have been completed by each employer and return to:

Health Occupations Credentialing  
 Kansas Department of Health and Environment  
 1000 SW Jackson, Suite 200  
 Topeka, KS 66612-1365

Phone number: (785) 296-6877  
 e-mail address: [kfritts@kdheks.gov](mailto:kfritts@kdheks.gov)

KDHE OFFICE USE ONLY

CNA	Instructor # _____	Approval Date ____-____-____	Disapproval Date ____-____-____
CMA	Instructor # _____	Approval Date ____-____-____	Disapproval Date ____-____-____
HHA	Instructor # _____	Approval Date ____-____-____	Disapproval Date ____-____-____

Reviewer Signature \_\_\_\_\_

Comments:

HEALTH OCCUPATIONS CREDENTIALING  
1000 SW Jackson, Suite 200  
Topeka, KS 66612-1365  
**CNA-CMA-HHA INSTRUCTOR EMPLOYMENT VERIFICATION**

**APPLICANT: COMPLETE THIS SECTION**

(Photocopy as needed and send to each employer listed on your application.)

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RN License Number \_\_\_\_/\_\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
(Last) (First) (M.I.)

Other Names Used \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City/State) (Zip)

Phone Number (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

By my signature, I authorize the release of employment verification from the facility named below to the Kansas Department of Health and Environment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMPLOYER: COMPLETE THIS SECTION**

Name of Facility \_\_\_\_\_ Telephone number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Type of facility: Adult Care Home \_\_\_\_ Hospital \_\_\_\_ Home Health Agency \_\_\_\_ Other (Explain) \_\_\_\_\_

Comments:

I certify that the individual named above is/was employed by me as an LPN or RN (Circle one)

from \_\_\_\_\_ to \_\_\_\_\_.

This individual was employed as a licensed nurse as follows (**number of hours per week must be included**):

In an adult care home or distinct-part long-term care unit from \_\_\_\_\_ to \_\_\_\_\_ Hours per week: \_\_\_\_\_

In home health care services from \_\_\_\_\_ to \_\_\_\_\_ Hours per week: \_\_\_\_\_

Other licensed nursing experience from \_\_\_\_\_ to \_\_\_\_\_ Hours per week: \_\_\_\_\_

Experience in administering medication \_\_\_\_ Yes \_\_\_\_ No

Please explain if other licensure setting \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_