

**North Carolina Department of Health and Human Services
Division of Health Service Regulation
Health Care Personnel Education and Credentialing Section
Existing Training Program – Faculty Removal Request Form**

INSTRUCTIONS:

- Complete the form if you're an existing state-approved training program.
- Email the completed form to dhsr.educationconsultant@dhhs.nc.gov.
- Contact the DHSR Education Consultant for your region with any questions.

PROGRAM INFORMATION:

Answer the questions below.

1. Date Submitted to DHSR (mm/dd/yyyy):

2. Name of School:

3. Name of Training Program:

4. Mailing Address (Street, City, Zip Code, County):

5. Site Address (Street, City, Zip Code, County):

6. Program Coordinator:
 - a. First and Last Name:

 - b. Telephone Number:

 - c. Email:

 - d. Fax Number:

7. Program Administrator:
 - a. First and Last Name:

 - b. Telephone Number:

 - c. Email:

 - d. Title:

8. Faculty Position:
Place an X beside the correct response.
 - a. Program Coordinator and Instructor: _____
 - b. Program Coordinator Only: _____
 - c. Instructor Only: _____

9. Training Program Numbers:
a. Nurse Aide I Training Program:

b. _____
Nurse Aide I Refresher Training Program:

c. _____
Geriatric Aide Training Program:

d. _____
Home Care Specialty Training for Nurse Aides Program:

FACULTY NAME:

Answer the questions below.

10. First and Last Name:

11. Email:

12. Registered Nurse License Number:

STATEMENT OF UNDERSTANDING:

- I understand the training program must meet the requirements set forth by federal and state rules, regulations, and requirements.
- I understand, per federal regulation 42 CFR §483.152, that students cannot perform any services to residents or patients for which they have not been trained and found proficient by the Instructor.
- I understand, per federal regulation 42 CFR §483.151, that the approval of a training program must be renewed by the North Carolina Division of Health Service Regulation every two (2) years.
- I understand, per federal regulation 42 CFR §483.152, that the training program must use the current version of the North Carolina State-approved curriculum and adhere to the policies and procedures approved by the North Carolina Division of Health Service Regulation.
- I understand, per federal regulations 42 CFR §483.151 and 42 CFR §483.152, that the training program faculty and clinical sites must be approved by the North Carolina Division of Health Service Regulation prior to implementation and the enrollment of students.
- I understand, per federal regulation 42 CFR §483.151, that modifications to the training program must be approved by the North Carolina Division of Health Service Regulation prior to implementation.
- I understand modifications to the training program required by the North Carolina Division of Health Service Regulation must be made in a timely manner.
- I understand, per federal regulation 42 CFR §483.152, that all classroom, laboratory and supervised practical training must be under the direct supervision of a North Carolina Division of Health Service Regulation approved Registered Nurse.
- I understand the training program must incorporate innovative instructional strategies that enable students to deliver quality, compassionate, and consistent basic nursing care. I further understand the training program must ensure objectives are met through instructor demonstration, student practice and demonstration of proficiency.
- I understand the classroom must contain instructional equipment and supplies, seating for the approved number of students as required, and adequate space to accommodate activities.
- I understand, per federal regulation 42 CFR §483.152, that each training program laboratory must be designed, equipped, and contain a sufficient quantity of supplies as shown in the Existing Training Program – Basic Equipment and Supply List.

- I understand, per federal regulation 42 CFR §483.151, that the training program location and policies must be made available to the North Carolina Division of Health Service Regulation upon request.
- I understand, per federal regulation 42 CFR §483.151, that the training program is required to maintain student records for a minimum of three (3) years. I further understand student records must be kept on site, kept in a locked file cabinet, kept in a locked area, and made available for review by the North Carolina Division of Health Service Regulation upon request.
- I understand, per federal regulation 42 CFR §483.151, that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program does not meet federal or state rules, regulations, and requirements.
- I understand, per federal regulation 42 CFR §483.151, that the North Carolina Division of Health Service Regulation may withdraw approval of a training program if it determines that the training program is not adhering to program documentation approved by the North Carolina Division of Health Service Regulation.
- I understand, per federal regulation 42 CFR §483.151, that the North Carolina Division of Health Service Regulation must withdraw approval of the training program if the training program refuses to permit unannounced visits by the North Carolina Division of Health Service Regulation.

ELECTRONIC SIGNATURE AGREEMENT:

You acknowledge and agree to the following statements:

- I certify that I have reviewed the entire document before signing.
- Your electronic signature will have the same legal effect and enforceability as your manual signature.
- No certification authority or other third-party verification is necessary to validate your electronic signature and the lack of such certification or third-party verification will not in any way effect the enforceability of your electronic signature.

ATTESTATION:

- I have read and agree to the Statement of Understanding
- I certify that the information in this form, and in the documentation required with the submission of this form, is truthful, accurate, and complete.
- I certify that the information in this form, and in the documentation required with the submission of this form, accurately represents the training program for which the North Carolina Division of Health Service Regulation approval is being requested.
- I will implement directives, policies, forms, and checklists as mandated by federal and state regulations and the North Carolina Division of Health Service Regulation.

Program Coordinator or Program Administrator:

First Name: _____
 Last Name: _____
 Signature: _____
 Today's Date (mm/dd/yyyy): _____