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

INSTRUCTIONS:

- Complete the form if you're establishing a new state-approved training program.
- Approval from the North Carolina Division of Health Service Regulation (DHSR) is required prior to the enrollment of students in the 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:
   Place an X beside the correct response.
   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: ______________________

NURSE FACULTY:

Answer the questions below.

10. First Name:
    ____
11. Middle Name:
    ____
12. Last Name:
    ____
13. Email:
    ____
14. Telephone Number:
    ____

ORIGINAL REGISTERED NURSE LICENSURE INFORMATION:

Answer the questions below.

15. Name on License:
    ____
16. License Number:
    ____
17. Date of Issuance:
    ____
18. State of Issuance:
    ____
19. License Expiration Date (mm/dd/yyyy):
    ____
20. Name of College or University:
    ____
21. Graduating Year From College or University:
    ____
22. Mailing Address of College or University (Street, City, State, Zip Code):
    ____

NORTH CAROLINA BOARD OF NURSING LICENSURE INFORMATION:

Answer the questions below.

23. Name on License:
24. License Number:
25. Date of Issuance:
26. License Expiration Date (mm/dd/yyyy):
27. Unencumbered License (Yes/No):
28. Temporary License (Yes/No):
29. Permanent License (Yes/No):

COMPACT STATE NURSING LICENSURE INFORMATION:

Answer the questions below.

30. Name on License:
31. License Number:
32. State of Issuance:
33. Date of Issuance:
34. License Expiration Date (mm/dd/yyyy):
35. Unencumbered License (Yes/No):
36. Temporary License (Yes/No):
37. Permanent License (Yes/No):

OTHER ACTIVE REGISTERED NURSE LICENSES:

Answer the questions below.

38. Name on License:
39. License Number:
40. State of Issuance:
41. Date of Issuance:
42. License Expiration Date (mm/dd/yyyy):

43. Unencumbered License (Yes/No):
44. Temporary License (Yes/No):
45. Permanent License (Yes/No):

FACULTY REQUIREMENTS:
Answer the questions below.

46. Does the Registered Nurse Meet the Required Faculty Qualifications (Yes/No):
47. Is the Registered Nurse Currently Employed in a Faculty Position at a North Carolina State-Approved Nurse Aide I Training Program (Yes/No):
48. If Yes to Question #47, Then Provide the Following Information:
    a. Name of Training Program:
    b. Training Program Numbers:
    c. Training Program Position (Program Coordinator, Instructor, or Both):
    d. Training Program Hire Date (mm/yyyy):
49. If No to Question #47, Then Provide the Following Information:

    Employment History #1:
    a. Hire Date (mm/yyyy):
    b. Last Date Worked (mm/yyyy):
    c. Employer Name:
    d. Position:
    e. Address (Street, City, State, Zip Code):
    f. Telephone Number:
    g. Full-Time Position (Yes/No):
    h. Part-Time Position (Yes/No):
    i. Part-Time Hours Per Week, If Applicable:
    j. Did You Provide Home Care Services (Yes/No):
    k. Did You Supervise Nurse Aides (Yes/No):

l. Did You Care For the Chronically Sick or Elderly (Yes/No): ____________

m. Identify Type of Facility:
Place an X beside the correct response.
- Nursing Home: ____________
- Hospital Skilled Nursing: ____________
- Medical Surgical: ____________
- Home Care: ____________
- Home Health: ____________
- Hospice: ____________
- Swing Bed Unit: ____________
- Intermediate Care Facility (ICF/IID): ____________
- Other (Please Specify): ____________

Employment History #2:

a. Hire Date (mm/yyyy): ____________

b. Last Date Worked (mm/yyyy): ____________

c. Employer Name: ____________

d. Position: ____________

e. Address (Street, City, State, Zip Code): ____________

f. Telephone Number: ____________

g. Full-Time Position (Yes/No): ____________

h. Part-Time Position (Yes/No): ____________

i. Part-Time Hours Per Week, If Applicable: ____________

j. Did You Provide Home Care Services (Yes/No): ____________

k. Did You Supervise Nurse Aides (Yes/No): ____________

l. Did You Care For the Chronically Sick or Elderly (Yes/No): ____________

m. Identify Type of Facility:
Place an X beside the correct response.
- Nursing Home: ____________
- Hospital Skilled Nursing: ____________
- Medical Surgical: ____________
- Home Care: ____________
- Home Health: ____________
- Hospice: ____________
- Swing Bed Unit: ____________

- Intermediate Care Facility (ICF/IID): ____________________
- Other (Please Specify): ____________________

Employment History #3:

a. Hire Date (mm/yyyy):
____
b. Last Date Worked (mm/yyyy):
____
c. Employer Name:
____
d. Position:
____
e. Address (Street, City, State, Zip Code):
____
f. Telephone Number:
____
g. Full-Time Position (Yes/No):
____
h. Part-Time Position (Yes/No):
____
i. Part-Time Hours Per Week, If Applicable:
____
j. Did You Provide Home Care Services (Yes/No):
____
k. Did You Supervise Nurse Aides (Yes/No):
____
l. Did You Care For the Chronically Sick or Elderly (Yes/No):
____
m. Identify Type of Facility:
Place an X beside the correct response.
    - Nursing Home: ____________________
    - Hospital Skilled Nursing: ____________________
    - Medical Surgical: ____________________
    - Home Care: ____________________
    - Home Health: ____________________
    - Hospice: ____________________
    - Swing Bed Unit: ____________________
    - Intermediate Care Facility (ICF/IID): ____________________
    - Other (Please Specify): ____________________

50. Teaching Adults:
Answer the questions below.
    a. Name of Training Course or Workshop:
    ____
    b. Course or Workshop Completion Date:
    ____
    c. Sponsored By:
    ____

d. Mailing Address (Street, City, State, Zip Code): ______________________________

e. Describe Course or Workshop Content: ______________________________

____

____

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 New 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.

Applicant for Faculty Position:
First Name: ______________________________
Last Name: ______________________________
Signature: ______________________________
Today’s Date (mm/dd/yyyy): ______________________________

Program Coordinator or Program Administrator:
First Name: ______________________________
Last Name: ______________________________
Signature: ______________________________
Today’s Date (mm/dd/yyyy): ______________________________