

# Nursing Assistant Training Program Instructional Staff Application Packet

## Contents:

1. 669-346 ...... Contents List and Mailing Information........................................ 1 page

2. 669-347 ...... Application Instructions Checklist.............................................. 2 pages

3. 669-348 ...... Nursing Assistant Training Program

Instructional Staff Program Application .................................... 3 pages 4. RCW/WAC and Online Website Links .......................................................... 1 page

In order to process your request, email your application and other documents to:

The Nursing Education Unit at [ncqac.education@doh.wa.gov](mailto:ncqac.education@doh.wa.gov).

## Contact us:

360-236-4703

DOH 669-346 August 2018

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# Application Instructions Checklist

The Nursing Care Quality Assurance Commission (NCQAC) has statutory authority through [**RCW 18.88A**](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.88A) to approve and review nursing assistant training program instructional staff in the state of Washington.

This application is for Registered Nurses or Licensed Practical Nurses (for non- medication assistant programs) who will be the theory and/or laboratory and/or clinical instructor in an approved nursing assistant training program. Guest speakers need not be listed. The use of additional instructional staff must be in accordance with

[**WAC 246-841**](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-841). Guest speakers must be approved by the program director and this staff member must not supplant the primary teaching duties of the instructor.

When the commission receives your application for a nursing assistant training program instructional staff it will be reviewed. The commission notifies the applicant in writing of any outstanding documentation needed to complete the process.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

### Check which applies:

Check which type of training program your agency will be providing. Complete an application for each type of program you provide.

### 1. Demographic Information:

**Legal Name:** List your full name: first, middle, and last.

**Address:** List the address we should use to send any information to you. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.

**Phone, Cell and Work numbers:** Enter your phone, cell, and work numbers.

**Email:** Enter your email address.

**Registered nurse or Licensed Practical Nurses (for non-medication assistant programs) license number and date of expiration:** Enter the license number and expiration date of the credential you currently hold.

**Name of nursing assistant training program:** Enter name of nursing assistant training program where you are currently an instructor.

**Mailing address:** Enter the mailing address, city, state, and zip code of nursing assistant training program.

**Phone:** Enter the phone number of the nursing assistant training program.

### 2. Personal Data Questions:

If you answer “yes” to the question in this section, you must provide an explanation.

DOH 669-347 August 2018 Page 1 of 2

### 3. Education:

List in date order, starting with most recent educational preparation. Attach additional pages if you need more space.

### 4. Experience:

List in date order, starting with most recent all work experience over the past three years. Attach additional pages if you need more space.

### 5. Primary Teaching Responsibility:

Check all that apply.

### 6. Applicant’s Attestation:

You must sign and date this for us to process the application.

DOH 669-347 August 2018 Page 2 of 2



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| --- | --- | --- | --- | --- | --- |
|  | | | | | Date Stamp Here |
| **Nursing Assistant Training Program Instructional Staff Application** | | | | | |
| **1. Demographic Information** | | | | | |
| **Check which one applies:**  **Note: Complete an application for each type of program you are applying for.**  Home Care Aide Bridge Program #       Medical Assistant Bridge Program #  Medication Assistant Endorsement Program #       Traditional Program # | | | | | |
| Name First, Middle, Last | | | | | |
| Address | | | | | |
| City | State | Zip Code | | County | |
| Phone (enter 10 digit #) | Cell (enter 10 digit #) | | | Work (enter 10 digit #) | |
| Email Address | | | | | |
| Registered Nurse or Licensed Practical Nurse Credential # | | | Credential Expiration Date | | |
| Name of nursing assistant training program | | | Phone (enter 10 digit #) | | |
| Nursing assistant training program mailing address | | | | | |
| City | State | Zip Code | | County | |
| **2. Personal Data Questions** | | | | | |
| 1. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?  Yes  No If yes, please explain. Attach additional pages if you need more space. 2. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferrer of suspended as an adult of juvenile in any state or jurisdiction?  Yes  No If yes, please explain. Attach additional pages if you need more space. 3. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?  Yes  No If yes, please explain. Attach additional pages if you need more space. | | | | | |

DOH 669-348 August 2018 Page 1 of 3

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3. Education and Training** | | | | | | | | |
| List in date order, starting with most recent educational preparation. Attach additional pages if you need more space. | | | | | | | | |
| Full Name, City and State/Schools Attended | | | | Degree Earned | | Entrance Date (mm/dd/yyyy) | | Ending Date (mm/dd/yyyy) |
|  | | | |  | |  | |  |
|  | | | |  | |  | |  |
|  | | | |  | |  | |  |
| **4. Experience** | | | | | | | | |
| List all experience in date order, starting with most recent. | | | | | | | | |
| Job Title: | Start Date (mm/dd/yyyy): | | | | End Date (mm/dd/yyyy): | | | |
| Agency Name: | | | | | | | | |
| Agency Address: | | | | | | | | |
| City: | | State: | | | Zip Code: | | | |
| Job Duties Performed: | | | | | | | | |
| Job Title: | Start Date (mm/dd/yyyy): | | | | End Date (mm/dd/yyyy): | | | |
| Agency Name: | | | | | | | | |
| Agency Address: | | | | | | | | |
| City: | | | State: | | | | Zip Code: | |
| Job Duties Performed: | | | | | | | | |
| Job Title: | Start Date (mm/dd/yyyy): | | | | End Date (mm/dd/yyyy): | | | |
| Agency Name: | | | | | | | | |
| Agency Address: | | | | | | | | |
| City: | | | State: | | | | Zip Code: | |
| Job Duties Performed: | | | | | | | | |
| Job Title: | Start Date (mm/dd/yyyy): | | | | End Date (mm/dd/yyyy): | | | |
| Agency Name: | | | | | | | | |
| Agency Address: | | | | | | | | |
| City: | | | State: | | | | Zip Code: | |
| Job Duties Performed: | | | | | | | | |
| Job Title: | Start Date (mm/dd/yyyy): | | | | End Date (mm/dd/yyyy): | | | |
| Agency Name: | | | | | | | | |
| Agency Address: | | | | | | | | |
| City: | | | State: | | | | Zip Code: | |
| Job Duties Performed: | | | | | | | | |
| DOH 669-348 August 2018 Page 2 of 3 | | | | | | | | |

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| **Please answer the following questions:**   1. Have you completed a course in adult instruction? Yes No If yes, please provide a copy of your certification of completion. 2. If you answered no to the question above, describe your experience teaching adult courses **over and above**  in- service education or patient teaching. Please be specific about when, where, and for how long. Attach additional pages if you need more space. 3. In accordance with Washington Administrative Code [(WAC) 246-841-470(7)(b)](http://app.leg.wa.gov/wac/default.aspx?cite=246-841-470), do you have a minimum of one year’s experience within the past three years caring for the elderly and/or chronically ill of any age?**** Yes No If yes, describe the location (organization and unit area), time-frame, and care duties. Please be specific. Attach additional pages if you need more space. |
| **5. Primary Teaching Responsibility** (Check all that apply) |
| Check which of the following your primary teaching responsibility will include:  Classroom Clinical Laboratory All |
| **6. Signature** |
| I certify that I have received, read, understood, and agree to comply with state laws and rules regulating nursing assistant training programs. I also certify that the information herein submitted is true to the best of my knowledge and belief.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signature of applicant Date |

DOH 669-348 August 2018 Page 3 of 3



# RCW/WAC and Online Website Links

## RCW/WAC Links

### [Nursing Assistant Training Program Laws, RCW 18.88A](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.88A) [Uniform Disciplinary Act, RCW 18.130](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130)

[**Administrative Procedure Act, RCW 34.05**](http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05)

[**Nursing Assistant Training Program Rules, WAC 246-841**](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.88A)

**On-line**

[**Nursing Care Quality Assurance Commission, Web Page**](http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission.aspx)

RCW/WAC and Online Website Links August 2018