

# Nursing Assistant Training Program Director Application Packet

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

The Nursing Education Unit at ncqac.education@doh.wa.gov

## Contact us:

360-236-4703

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# Application Instructions Checklist

The Nursing Care Quality Assurance Commission 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 directors in the state of Washington.

When the Commission receives your application for a program director, it will be reviewed. The Commission notifies you in writing of any outstanding documentation needed to complete the process.

All information must 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 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.

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

### [ ]  3. Education:

List in date order, starting with the most recent educational preparation. Answer the questions listed, and provide documentation if requested. Attach additional pages if you need more space.

### [ ]  4. Experience:

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

### [ ]  5. Applicant’s Attestation:

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

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|  |  |
| --- | --- |
|  | Date Stamp Here |
| **Nursing Assistant Training Program Director Application** |
| **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 #       |
| **1. Demographic Information** |
| 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 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.      1. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? **[ ]** Yes **[ ]** No

If yes, please explain. Attach additional pages if you need more space.      1. 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.       |

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| --- |
| **3. Education and Training** |
| List in date order, starting with most recent, your 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) |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Please answer the following questions:**Have you completed a course in adult instruction? [ ] Yes [ ] NoIf yes, please provide a copy of your certification of completion.If you answered no to the question above, describe below 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.       |
| **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:       |

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|  |  |  |
| --- | --- | --- |
| Job Title:       | Start Date (mm/dd/yyyy):       | End Date (mm/dd/yyyy):       |
| Agency Name:       |
| Agency Address:       |
| City:       | State:       | Zip Code:       |
| Job Duties Performed:       |
| **Please answer the following questions:**What is your present position at this facility or institution?     How long have you practiced as a registered nurse?       How many years of registered nurse practice have been in direct patient care?       |
| **5. Signature** |
| I certify that I have received, read, understand, 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 |

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# 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**

RCW/WAC and Online Website Links August 2018