

# Nursing Assistant Training Program Application Packet

## Contents:

1. 669-355 ...... Contents List and Mailing Information........................................ 1 page

2. 669-356 ...... Application Instructions Checklist............................................. 3 pages

3. 669-357 ...... Nursing Assistant Training Program Application ...................... 4 pages 4. RCW/WAC and Online Web Site 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:

360-236-4700

(This page intentionally left blank.)



# 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 programs in the state of Washington.

When the commission receives your application for a nursing assistant training program it will be reviewed. The commission will notify you 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:

**Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #s.

**Federal ID Number (FEIN #):** Enter your Federal ID Number, if the business has been issued one.

**Legal Name:** List the legal name of the sponsoring healthcare facility, hospital, school or other entity.

**Mailing Address:** Enter the training program’s complete mailing address.

**Phone and Fax Numbers:** Enter the training program’s phone and fax numbers.

**Email and Web Address:** Enter the training program’s email and web addresses, if applicable.

**Physical Address:** Enter the training program’s complete physical address if it is different from the mailing address previously listed.

**Name and email of agency administrator, vocational director, department head or chief administrative officer:** Enter the name and email of the training program’s agency administrator, vocational director, department head or chief administrative officer.

**Name of program director:** Enter name of program director.

**Email Address and phone number:** Enter the email address and phone number of the program director.

### 2. Program Information:

Describe the details of your training program in the spaces provided. Attach additional pages if you need more space.

1. Describe the training laboratory and the personal care equipment used for the practice of clinical skills.
2. Describe the classroom space allotted to your training program. Specify type of room, square footage, self-contained or shared space, room equipment, classroom furniture, maximum number of students that can comfortably fit, other uses of this room during non-class time, and the availability/location of teaching materials and audio-visual equipment.
3. List the teaching resources for the program. Such as, name and publication date of textbooks and audio-visual equipment.
4. List the number of hours proposed for your training program (include hours in the classroom laboratory, and the clinical facility setting).
5. List all the instructors and their qualifications.
6. List all facilities where clinical training will be conducted through your training program.

### 3. Applicant’s Attestation:

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

**Additional Requirements:**

All programs must provide the following documents with your application:

1. Program Director application.
2. Program Declaration of Program Director.
3. Program Instructional Staff application.
4. A list of course objectives for your training program.
5. The curriculum and schedule of class presentations and clinical rotations.
6. Evidence of content that will lead to the achievement of all required nursing assistant competencies in the National Council State Boards of Nursing curriculum. (Complete this only if you are applying for a medication assistant training program.)
7. A sample lesson plan for one core unit of the curriculum outline. This includes a lesson plan objectives, supporting sub-objectives, and student learning outcomes.
8. The skills checklist and competency evaluation used in your program for skills achievement verification.
9. A description of the evaluation methods and your program requirements for passing. For example, tests, quizzes, and homework presentations.
10. Copies of the required affiliation agreement with facilities where clinical training is conducted. (This only applies to non-facility based programs.)
11. Sample of student record form to be used by training program.
12. The program must provide evidence that it is approved by the appropriate organization if applicable.
    1. The State Board for Community and Technical Colleges;
    2. The Superintendent of Public Instruction; or
    3. The Workforce Training and Education Coordinating Board.

(This page intentionally left blank.)



Date Stamp Here

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nursing Assistant Training Program 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** | | | | |
| UBI # | | Federal Tax ID (FEIN) # | | |
| Legal name of sponsoring healthcare agency, facility, hospital, school or other entity | | | | |
| Mailing Address | | | | |
| City | State | | Zip Code | County |
| Phone (enter 10 digit #) | | | Fax (enter 10 digit #) | |
| Email Address | | | Web Address | |
| Physical Address (if different from mailing) | | | | |
| City | State | | Zip Code | County |
| Name of agency administrator, vocational director, department head or chief administrative officer | | | | |
| Email Address | | | | |
| Name of program director | | | | |
| Email Address | | | Phone (enter 10 digit #) | |

|  |  |  |  |
| --- | --- | --- | --- |
| **2. Program Information** | | | |
| **a. Training Laboratory and the personal care equipment** | | | |
| Describe the training laboratory and the personal care equipment used for the practice of clinical skills. Attach additional pages if you need more space. | | | |
| **b. Classroom Space** | | | |
| Describe the classroom space allotted to your training program. Attach additional pages if you need more space. | | | |
| Is this classroom off-site, or located elsewhere from the physical address listed on page one? Yes No  If yes, provide the address of the classroom. | | | |
| **c. Teaching Resources** | | | |
| List the teaching resources for your training program. Attach additional pages if you need more space. | | | |
| **d. Training Program Hours** | | | |
| List the number of hours proposed for your training program. Attach additional pages if you need more space. | | | |
| Classroom Hours: | | Lab Hours: | |
| Practice hours in the facility: | | Total Hours: | |
| Additional Comments: | | | |
| **e. Course Instructors** | | | |
| List all instructors of your training program and submit applications for each instructor listed. Attach additional pages if you need more space. | | | |
|  | |  | |
|  | |  | |
|  | |  | |
|  | |  | |
| **f. Facilities** | | | |
| List all facilities where clinical training will be conducted through your training program. Attach additional pages if you need more space. | | | |
| Name of facility | Address | | Phone (enter 10 digit #) |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |

|  |
| --- |
| **3. Signature** |
| I representing  Name of program director Name of nursing assistant program  hereby acknowledge my understanding that the application process for a nursing assistant training program requires approval by the Nursing Care Quality Assurance Commission (NCQAC), before classes can be offered. I further understand that I must notify the commission whenever significant changes for the training program occur in personnel, curriculum, program legal status, program name, ownership, credit status impacting the program’s ability to sustain itself financially, classroom location, or sites used for clinical training. I will notify the commission within 72 hours when I am no longer the program director.    Signature of applicant Registered Nurse License #  Date (mm/dd/yyyy) |

(This page intentionally left blank.)



# 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