# **Nursing Refresher Program Approval Application** **Packet**

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**In order to process your request:**

**Email your application and other documents to:** WABONEducationUnit@doh.wa.gov

**Only electronic submissions will be accepted.**

**Contact us:**

360-236-4703

WABONEducationUnit@doh.wa.gov

**Application Instructions Checklist**

Thank you for your interest in offering a nursing refresher program in Washington State. The Washington State Board of Nursing has statutory authority through **RCW 18.79.110** to reestablish criteria for proof of reasonable currency of knowledge and skills as a basis for safe practice after the years in active or lapsed status. Nursing refresher programs must receive board approval before admitting students.

When the board receives the application for a nursing refresher program it will be reviewed. The board notifies 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.

1. [ ]  **Demographic Information**

[ ]  **Name of Educational Institution:** Enter the name of the educational institution.

[ ]  **Physical Address:** Enter the refresher program complete mailing address.

[ ]  **Phone and Fax Numbers:** Enter the refresher program phone and fax number.

[ ]  **Email and Web Address:** Enter the refresher program email and web addresses, if applicable.

[ ]  **Type of Ownership:** Enter type of ownership of the refresher program. Please indicate if you are a for-profit or not-for-profit organization.

[ ]  **Credit Status:** Enter financial credit status of the Educational Institutional Contact

1. [ ]  **Contact Information:** Enter the name of the contact person, title, address, email, phone, name of the university, college’s president, or program owner, their title, address, email and phone. Include an organizational chart with names of administrative staff.
2. [ ]  **Type of Program:** Check all that apply.
3. [ ]  **Mode of Education:** Check all that apply. If your primary location (physical location) is not in Washington, please complete section five.
4. [ ]  **Required Information for New Applications:** Complete this section for program approval.
5. [ ]  **Signature:**

[ ]  **Signature of legal owner or authorized representative.**

**[ ]  Date signed.**

**[ ]  Print name of legal owner or authorized representative.**

**[ ]  Print title of legal owner or authorized representative.**

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| **Proposed Nursing Refresher Program Approval Application** |
| 1. **Demographic Information**
 |
| **Name of Educational Institution:**Click or tap here to enter text. |
| **Physical Address:**Click or tap here to enter text. |
| **City:**Click or tap here to enter text. | **State:**Click or tap here to enter text. | **Zip Code:**Click or tap here to enter text. | **County:**Click or tap here to enter text. |
| **Mailing Address:**Click or tap here to enter text. |
| **City:**Click here | **State:**Click here | **Zip Code:**Click here | **County:**Click here |
| **Email Address:**Click or tap here to enter text. | **Web Address:**Click or tap here to enter text. |
| **Phone (enter 10 digit #):**Click or tap here to enter text. | **Fax (enter 10 digit #):**Click or tap here to enter text. |
| **Type of Ownership:** | **Financial Credit Status: See the** [**U.S. Securities and**](http://www.sec.gov/answers/nrsro.htm) [**Exchange Commission webpage**](http://www.sec.gov/answers/nrsro.htm) **for more information.**Click or tap here to enter text. |
| 1. **Contact Information**
 |
| **Name of Contact Person:**Click or tap here to enter text. | **Title:**Click or tap here to enter text. |
| **Physical Address:**Click or tap here to enter text. |
| **City:**Click here | **State:**Click here | **Zip Code:**Click here | **County:**Click here |
| **Email Address:**Click or tap here to enter text. | **Phone (enter 10 digit #):**Click or tap here to enter text. |
| **University/College President or Program Owner:**Click or tap here to enter text. | **Title:**Click or tap here to enter text. |
| **Physical Address:**Click or tap here to enter text. |
| **City:**Click here | **State:**Click here | **Zip Code:**Click here | **County:**Click here |
| **Email Address:**Click or tap here to enter text. | **Phone (enter 10 digit #):**Click or tap here to enter text. |
| 1. **Type of Program: (Check all that apply)**
 |
| **[ ]** Practical Nurse Refresher Program [ ]  Registered Nurse Refresher Program |
| 1. **Mode of Education: (Check all that apply)**
 |
| [ ]  Classroom program in Washington State [ ]  Classroom program outside of Washington State[ ]  Clinical rotation in Washington State[ ]  Clinical rotation outside of Washington State[ ]  Online program based in Washington State [ ]  Online program based outside of Washington State[ ]  Other Click or tap here to enter text. |
| 1. **Required Information: (For proposed new programs)**

**Please provide a written narrative and supporting documents that address each of the following items. This section serves as the application for program development (feasibility study).** |
| 1. Type of nursing refresher program. (e.g. LPN, RN)
2. Program philosophy, purpose of course objectives.
3. Evidence of financial resources; including funding source.
4. Designated nurse administrator with unencumbered Washington State RN (ARNP as appropriate) license and qualified academically and professionally as appropriate for the course level.
5. Provide course content, length, hours, methods of instruction and learning experiences as stated in

[WAC 246-840-563](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-563), [WAC 246-840-564](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-564), [WAC 246-840-566](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-566), [WAC 246-840-567](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-567) and/or [WAC 246-840-568](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-568).1. Provide tentative time schedule for planning and initiating the program.
2. Provide availability of adequate academic facilities and/or on-line teaching methodologies used by the program.
3. Identify the faculty member(s) responsible for the student’s learning experience, with the educational and professional qualifications including Washington State licensure.
4. Provide written plans for validating the student’s competency.
5. Provide evidence that the clinical experience in skills and knowledge prior to actual clinical practice is planned, developed, has oversight and is evaluated.
6. Provide plans to obtain practice experience of students at each location.
7. Provide process of regular course evaluation by faculty and students. Explain how you plan to allow students to evaluate faculty and sites.
8. Written policies including:
	1. Admission requirements, progression requirements and grading criteria, dismissal criteria, clinical and practice requirements, grievance process, student expectations and responsibilities, program cost and length of program;
	2. Evidence that faculty is responsible and accountable for managing clinical learning experiences of students.

**Note: the maximum faculty to student ratio for refresher LPN and RN programs is 1:12; ARNP 1:6*** 1. Process for the evaluation of affiliating agencies/clinical facilities or clinical practice settings and the frequency of evaluation;
	2. When clinical preceptors or clinical teaching assistant are used, written agreements between the program, clinical preceptor, or clinical teaching assistant, and the affiliating agency, when applicable, delineating the functions and responsibilities of the parties involved; See [WAC 246-840-533](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-533);
	3. Measure evidence-based methods of student achievement of stated theory and clinical objectives;
	4. Written criteria for the selection of competent clinical preceptors and verification of qualifications; and
	5. Process for the evaluation of student performance in clinical learning experiences, including the criteria for evaluating;
	6. Student licensure requirements;
	7. Maintenance of student records.

**Note: Please include any additional information important to your application** |
| 1. **Signature**
 |
| I certify that I have received, read, understood, and agree to comply with state laws and rules regulating nursing refresher programs. I also certify that the information herein submitted is true to the best of my knowledge and belief. |
| Signature of owner/authorized representative | Date: Click or tap to enter a date. |
| Click or tap here to enter text.Print Name | Click or tap here to enter text.Title |

# RCW/WAC and Online Web Site Links

## RCW/WAC Links

Nursing Care [**RCW 18.79**](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79)

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 Education Programs........................... [**WAC 246-840-550**](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-550)to [**WAC 246-840-575**](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-575)

## On-line

Washington State Board of Nursing [**Web Page**](http://www.doh.wa.gov/LicensesPermitsandCertificates/NursingCommission.aspx)

RCW/WAC and Online Web Site Links - December 2023