**Nursing Assistant Training Program Instructor Application Packet**

**Instructions:**

* To apply to be an Instructor, please complete the following application, and email to WABONEducation@doh.wa.gov

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| Nursing Assistant Training Program Instructor Application |
| **Check each type of program you are applying for and add the program number.** [ ]  Traditional Program #  [ ]  Medical Assistant Bridge Program # [ ]  Home Care Aide Bridge Program #   [ ]  Medication Assistant Endorsement Program #   |
| 1. Demographic Information
 |
| Name (First, Middle, Last)Click or tap here to enter text.  |
| Address  Click or tap here to enter text. |
| City *Enter City* | State*Enter State* | Zip Code  *Enter Zip Code* | County *Enter County* |
| Phone (enter 10 digits #) *Enter #* | Cell (Enter 10 digits #) *Enter #* | Work (enter 10 digits #) *Enter #* |
| Email Address *Enter Email* |
| Registered Nurse or Licensure Practical Nurse Credential # *Enter Credential #* | Credential Expiration Date: *Enter Date* |
| Name of Nursing Assistant Training Program *Enter Name* |
| Physical Address of Nursing Assistant Training Program  *Enter Street Address* | Phone Number (enter 10 digits #) *Enter #* |
| City  *Enter City* | StateWA | Zip Code *Enter Zip Code* | County *Enter County* |
| 1. Personal Data Questions [WAC 246-841A-430]
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| **Please answer the following 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:
2. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred of suspended as an adult or juvenile in any state or jurisdiction? [ ]  **YES** [ ]  **NO -- If YES**, please explain:
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:
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| 1. **Education and Training** [WAC 246-841A-430]
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| **List all experience starting with your educational and training preparation in date order. Attach additional pages if you need more space.** |
| **Full Name, City and State/Schools Attended** | **Degree/Certification Completed** | **Entrance Date** | **Ending Date** |
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| **Please answer the following questions [WAC 246-841A-430]:** 1. Have you completed a training course on adult instruction? [ ]  **YES** [ ]  **NO -- If YES**, please also submit a copy of your certificate of completion or transcript.

 ***--OR--***1. Do you have one year of experience teaching adults, beyond patient teaching? [ ]  **YES** [ ]  **NO** -- **If YES**, please explain:

 ***--OR--***1. Are you working exclusively in a secondary or postsecondary educational setting? [ ]  **YES** [ ]  **NO**
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| 1. **Experience [WAC 246-841A-430]**
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| **List all experience in date order, starting with the most recent.**  |
| Job Title: | Start Date: | End Date: |
| Agency Name: |
| Agency Address:  |
| Job Duties Performed: |

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| Job Title:  | Start Date: | End Date: |
| Agency Name:  |
| Agency Address:  |
| Job Duties Performed:  |
| Job Title: | Start Date: | End Date: |
| Agency Name:  |
| Agency Address:  |
| Job Duties Performed: |
| Job Title: | Start Date: | End Date: |
| Agency Name:  |
| Agency Address:  |
| Job Duties Performed:  |
| Job Title: | Start Date: | End Date: |
| Agency Name:  |
| Agency Address:  |
| Job Duties Performed: |
| Job Title: | Start Date: | End Date: |
| Agency Name:  |
| Agency Address:  |
| Job Duties Performed:  |

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| **Please answer the following questions (WAC 246-841A-430):** 1. Have you completed one year of verifiable paid or unpaid work experience as a licensed nurse within the past three years providing direct patient care for the elderly or chronically ill of any age. [ ]  **YES** [ ]  **NO**

***OR***1. Have you completed three years of verifiable paid experience as a licensed nurse at any time providing direct patient care for the elderly or chronically ill of any age ***AND*** verifiable paid or unpaid work experience as a licensed nurse in any role for at least one of the last three years. [ ]  **YES** [ ]  **NO**
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| 1. **Signature**
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| I certify that I provided the information in this application, and it is true to the best of my knowledge and belief. I agree to comply with all regulations for nursing assistant training programs, including but not limited to **WAC Chapter 246-841A**. **Signature of applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**   *Enter Date*  **Please print, sign, and return via email to** **WABONEducation@doh.wa.gov** |