**Nursing Assistant Training Program Director Application Packet**

**Instructions:**

* To apply be a Training Program Director, please complete the following application.

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| Nursing Assistant Training Program Director Application | | | | |
| 1. Demographic Information | | | | |
| **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 # | | | | |
| Name (First, Middle, Last):  *Enter Name* | | | | |
| Address:    *Enter personal address here* | | | | |
| City:    *Enter city* | State:    *Enter state* | Zip Code:    *Enter Zip* | | 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* | State:  WA | Zip Code:    *Enter Zip Code* | | County:    *Enter County* |
| 1. Personal Data Questions [[WAC 246-841A-430](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-430&pdf=true)] | | | | |
| **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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| **3. Education and Training** [[WAC 246-841A-430](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-430&pdf=true)] | | | | |
| **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** |
|  |  | *Select Date (MM/YY)* | | *Select Date (MM/YY)* |
|  |  | *Select Date (MM/YY)* | | *Select Date (MM/YY)* |
|  |  | *Select Date (MM/YY)* | | *Select Date (MM/YY)* |
| **Please answer the following questions [**[**WAC 246-841A-430**](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-430&pdf=true)**]:**   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** | | | | |
| 1. **Experience [**[**WAC 246-841A-430**](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-430&pdf=true)**]** | | | | |
| **List all experience in date order, starting with the most recent:** | | | | |
| Job Title: | Start Date:  *Select Date MM/YY* | | End Date:  *Select Date MM/YY* | |
| Agency Name: | | | | |
| Agency Address: | | | | |
| Job Duties Performed: | | | | |
| Job Title: | Start Date:  *Select Date MM/YY* | | End Date:  *Select Date MM/YY* | |
| Agency Name: | | | | |
| Agency Address: | | | | |
| Job Duties Performed: | | | | |
| Job Title: | Start Date:  *Select Date MM/YY* | | End Date:  *Select Date MM/YY* | |
| Agency Name: | | | | |
| Agency Address: | | | | |
| Job Duties Performed: | | | | |
| Job Title: | Start Date:  *Select Date MM/YY* | | End Date:  *Select Date MM/YY* | |
| Agency Name: | | | | |
| Agency Address: | | | | |
| Job Duties Performed: | | | | |
| 1. **Required Online Orientation** | | | | |
| **Please indicate the date you completed or will complete the online orientation for directors *(see date options*** ***on our*** [***website***](https://nursing.wa.gov/education/nursing-assistant-education/na-program-info/add-or-remove-program-personnel/add-program-personnel/add-new-program-director) ***or email*** [WABONNursingAssistantsED@doh.wa.gov](mailto:WABONNursingAssistantsED@doh.wa.gov) ***):***  *Select Date*  **Please Note**: Program Directors must complete online orientation within 30 days of approval [[WAC 246-841A-430(3)]](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A-430&pdf=true) | | | | |
| 1. **Signature** | | | | |
| 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](https://app.leg.wa.gov/WAC/default.aspx?cite=246-841A).  **Signature of applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** *Selectr Date*  **Please print, sign, and return via email to** [WABONNursingAssistantsED@doh.wa.gov](mailto:WABONNursingAssistantsED@doh.wa.gov) | | | | |