**Nursing Assistant Training Program Instructor Application Packet**

**Instructions:**

* To apply to be an Instructor, please complete the following application, and email to [WABONNursingAssistantsED@doh.wa.gov](mailto:WABONNursingAssistantsED@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* | | | | State  WA | | Zip Code    *Enter Zip Code* | | | | County    *Enter County* |
| 1. Personal Data Questions [WAC 246-841A-430] | | | | | | | | | | |
| **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: | | | | | | | | | | |
| 1. **Education and Training** [WAC 246-841A-430] | | | | | | | | | | |
| **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** | | | | | | | | | | |
| 1. **Experience [WAC 246-841A-430]** | | | | | | | | | | |
| **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** |
| 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**.  **Signature of applicant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**   *Enter Date*  **Please print, sign, and return via email to** [**WABONNursingAssistantsED@doh.wa.gov**](mailto:WABONNursingAssistantsED@doh.wa.gov) |