2709 Mail Service Center
Raleigh, NC 27699-2709
Division of Health Service Regulation

Health Care Personnel Education and Credentialing Section

Phone: 919-855-3970
Fax: 919-733-9764
N.C. Department of Health and Human Services

NURSE AIDE I TRAINING PROGRAM
FACULTY APPROVAL REQUEST FORM CHECKLIST

INSTRUCTIONS:
All Nurse Aide I Training Faculty must meet the requirements as specified below. Please use this form to evaluate potential faculty.

- Complete a Faculty Approval Request Form for each member of your nurse aide faculty.
- This form can be found on our website: www.ncnar.org.
- Complete the Faculty Approval Request Form by including information that demonstrates the requirements below.
- Sign and fax each applicant's form separately to DHSR at 919-733-9764.

NOTE:
This page is a checklist. Please do not return this checklist to DHSR. It is for your own records.

PROGRAM COORDINATOR:

MEETS ✓	REQUIREMENTS
☐	1. The applicant is a registered nurse with an unencumbered license.
☐	2. The applicant is licensed to practice in North Carolina.
☐	3. The applicant has at least two (2) years (4000 hours) of experience as a registered nurse in the United States.
☐	4. The applicant has at least one (1) year (2000 hours) of RN experience in the provision of long-term care facility services in the United States demonstrated by: a. working in a long-term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital, **or** b. supervising or teaching students in a long-term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital.

INSTRUCTOR:

MEETS ✓	REQUIREMENTS
☐	1. The applicant is a registered nurse with an unencumbered license.
☐	2. The applicant is licensed to practice in North Carolina.
☐	3. The applicant has at least two (2) years (4000 hours) of experience as a registered nurse in the United States.
☐	4. The applicant meets at least **one** of the following: a. completion of a course in teaching adults; b. experience in teaching adults; or c. experience in supervising nurse aides.

NURSE AIDE I TRAINING
FACULTY APPROVAL REQUEST FORM

Please Print Legibly.

Date:		
School/Facility:		
Mailing Address:		
City:	County:	Zip Code:
Program Coordinator's Name:		
Program Coordinator's Phone #: (include area code)		Direct Extension:
Program Coordinator's Fax #: (include area code)		
Program Coordinator's E-mail Address:		
Program Coordinator's Date of Hire: Month: _____ Day: _____ Year: _____		
Enter All Applicable Program Numbers in the Spaces Below.		
NAT Program #(s): _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____		
Refresher Program #(s): _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____, _____		
Geriatric Aide Program #(s): _____, _____, _____, _____, _____		
Home Care Aide Program #(s): _____, _____, _____, _____, _____		

✓	**Position(s) Requested** (Check all boxes that apply)	**Applicant's Name** (Name that appears on RN license)
☐	Program Coordinator for NAT	First:
☐	Program Coordinator for Refresher	Middle:
☐	Instructor	Last:

Enter the RN Licensure Information Below.
State of Original RN Licensure:
Date of Original RN Licensure: Month: _____ Day: _____ Year: _____

☐ N.C. RN License # from N.C. Board of Nursing Web Site: _____	☐ Permanent **or** ☐ Temporary
☐ Compact State RN License #: _____	☐ Permanent **or** ☐ Temporary
☐ Other Active State RN License #: _____	☐ Permanent **or** ☐ Temporary
License Expiration Date: Month: _____ Day: _____ Year: _____	
License is Unencumbered: ☐ Yes ☐ No	
N.C. Board of Nursing Verification Number: (attach the verification form to this application)	
Enter the Basic RN Nursing Education Information Below.	
Name of College/University/School of Nursing:	
Street Address:	
City/State/Zip Code:	
Graduation Year:	
Instructors Currently Employed at N.C. State-approved Nurse Aide I Training Programs	
Is the RN <u>currently</u> employed as an instructor at a North Carolina state-approved Nurse Aide I training program? ☐ **Yes** ☐ **No** If **No**, please complete the employment history, teaching experience and teaching methodology course information on pages 3 through 5. If **Yes**, please list the program name and hire date for each training program.	
Program Name:	Hire Date: Month: _____ Year: _____
Program Name:	Hire Date: Month: _____ Year: _____
Program Name:	Hire Date: Month: _____ Year: _____

ONLY RN EXPERIENCE THAT DEMONSTRATES REQUIREMENTS

NOTE:
If you are currently employed as an instructor at a North Carolina state-approved Nurse Aide I training program, then you are not required to complete the following sections:

- Employment history, Teaching experience, Teaching methodology course

However, you are required to sign the document on the last page.

Registered Nursing Employment History (1)			
Dates From: Month: _____ Year: _____		**Dates To**: Month: _____ Year: _____	
Facility:		Position:	
Type of Facility:		☐ Full Time ☐ Part Time Hours/Week: _____	
Physical Address:			
City:	State:	Zip Code:	
Phone number (include area code):			
Check All Boxes that Apply to Employment History (1)			
☐ Nursing Home	☐ ICF/MR	☐ Home Care	☐ Hospice
☐ Hospital SNF	☐ Med/Surg	☐ Home Health	☐ Swing Bed Unit
☐ Supervised Nurse Aides as Part of the Job	☐ Cared for Chronically Ill or Elderly	☐ Other: _____	

Registered Nursing Employment History (2)			
Dates From: Month: _____ Year: _____		**Dates To**: Month: _____ Year: _____	
Facility:		Position:	
Type of Facility:		☐ Full Time ☐ Part Time Hours/Week: _____	
Physical Address:			
City:	State:	Zip Code:	
Phone number (include area code):			
Check All Boxes that Apply to Employment History (2)			
☐ Nursing Home	☐ ICF/MR	☐ Home Care	☐ Hospice
☐ Hospital SNF	☐ Med/Surg	☐ Home Health	☐ Swing Bed Unit
☐ Supervised Nurse Aides as Part of the Job	☐ Cared for Chronically Ill or Elderly	☐ Other: _____	

Registered Nursing Employment History (3)			
Dates From: Month: _____ Year: _____		**Dates To**: Month: _____ Year: _____	
Facility:		Position:	
Type of Facility:		☐ Full Time ☐ Part Time Hours/Week: _____	
Physical Address:			
City:	State:	Zip Code:	
Phone number (include area code):			
Check All Boxes that Apply to Employment History (3)			
☐ Nursing Home	☐ ICF/MR	☐ Home Care	☐ Hospice
☐ Hospital SNF	☐ Med/Surg	☐ Home Health	☐ Swing Bed Unit
☐ Supervised Nurse Aides as Part of the Job	☐ Cared for Chronically Ill or Elderly	☐ Other: _____	
Adult Teaching Experience (1)			
Dates From: Month: _____ Year: _____		**Dates To**: Month: _____ Year: _____	
Facility:		Describe Experience:	
Address:			
City:			
State:			
Zip Code:			
Phone number: (include area code)			
Adult Teaching Experience (2)			
Dates From: Month: _____ Year: _____		**Dates To**: Month: _____ Year: _____	
Facility:		Describe Experience:	
Address:			
City:			
Zip Code:			
State:			
Phone number: (include area code)			

Teaching Methodology Course	
Sponsored by:	
Address:	
City: State: Zip Code:	
Course Content:	Date Completed: Month: _____ Day: _____ Year: _____

I certify that the information in this application is correct and accurate to the best of my knowledge and that the minimum requirements for the position(s) requested have been met.

RN Applicant Name (Print): _____

RN Applicant Signature: _____

Date: _____

I certify that I have reviewed the information submitted by the applicant and the Faculty Approval Request Form submitted to DHSR is complete and accurate to the best of my knowledge.

Nurse Aide I Program Coordinator or Administrator Name: _____

Program Coordinator or Administrator Signature: _____

Date: _____