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

GERIATRIC AIDE TRAINING PROGRAM FOR REGISTRY LISTING COMMUNITY COLLEGE APPROVAL APPLICATION

Community College Name:	
Mailing Address:	Area Code/Telephone Number:
	Area Code/Fax Number:
Site Address:	Program Coordinator's E-mail address:

Note: Please complete all appropriate blanks. Incomplete forms will be returned.

REQUIRED HOURS: Classroom Hours = 75 Clinical Hours = 25 Total Hours = 100

Specify Curriculum Type: ☐ Continuing Education ☐ Curriculum

STATEMENT OF UNDERSTANDING

- I understand that approval to offer this program is based on our agency using the state-approved geriatric aide curriculum. I understand that I must teach, at a minimum, 75 hours of content, to include all modules as written in the curriculum, and provide 25 hours of clinical as directed. I understand that students must be listed on the Nurse Aide I Registry prior to attending the course. I further understand our agency may be required to make modifications to this program as requested by North Carolina Division of Health Service Regulation (DHSR). Modifications made by the state to the state-approved curriculum and provided to our agency will be incorporated into the currently approved program under which our agency operates.
- I understand that a college must require a minimum numerical grade of 75 as the final theory grade and a lab/activity grade of pass/fail.
- I understand that changes in faculty or clinical sites must be approved by the DHSR prior to implementation.
- I understand DHSR may withdraw approval of this training program if it determines that the program does not meet state requirements.
- I certify that class rosters with records of successful completion of the course will be made available to DHSR upon request.

_____ _____
Signature of Program Coordinator Date

_____ _____
Signature of Administrator Date

Clinical Sites

Clinical Site #1

Name: _____

Address: _____

Area Code/Telephone Number: _____

Clinical Site #2

Name: _____

Address: _____

Area Code/Telephone Number: _____

Clinical Site #3

Name: _____

Address: _____

Area Code/Telephone Number: _____

Attach an additional sheet with the above information if you have more than three (3) clinical sites.

FACULTY: (Faculty Approval Request forms can be found at www.ncnar.org)

Program Coordinator: _____ **RN Certificate Number** _____

☐ Previously approved as NAI program coordinator **OR** ☐ Faculty approval form is attached.

Will the PC serve as an instructor? ☐ yes ☐ no

Instructor: _____ **RN Certificate Number** _____

☐ Previously approved as NAI instructor **OR** ☐ Faculty approval form is attached.

Instructor: _____ **RN Certificate Number** _____

☐ Previously approved as NAI instructor **OR** ☐ Faculty approval form is attached.

Instructor: _____ **RN Certificate Number** _____

☐ Previously approved as NAI instructor **OR** ☐ Faculty approval form is attached.

COMPLETING THE APPLICATION PROCESS

Please e-mail (pdf only) your application to brenda.sanders@dhhs.nc.gov or fax to 919-733-9764.

Please contact Ms. Sanders at (919) 855-3970 if you need further information.

FOR OFFICE USE ONLY - DO NOT WRITE IN THIS BOX	
Program # Assigned _____	_____ **Continuing Education** _____ **Curriculum**