Reset Form

APPLICATION FOR APPROVAL TO OPERATE A NURSE AIDE TRAINING PROGRAM

State Form 629 (R4 / 7-21)
Indiana Department of Health – Division of Health Care Education and Quality

INDIANA DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE EDUCATION AND QUALITY
2 North Meridian Street, Suite 4-B
Indianapolis, IN 46204

INSTRUCTIONS:

1. *Please complete the appropriate sections on both sides of the application.* ***All applications must be completed.***
2. *Please use additional applications for more than one program director/delegated instructor and/or additional clinical sites.*
3. *Mail the completed application, along with all requested documentation, to the division at the above address.*
4. *Retain a copy of this application for your records.*

SECTION A: Training program information

TYPE OF TRAINING PROGRAM:
☐ Facility based ☐ Vocational school (accredited school or college based) ☐ Non-facility based (independent entity)

APPLICATION PURPOSE *(check all that apply)*:
☐ Initial approval ☐ Renewal ☐ Add Clinical Site ☐ Add Program Director ☐ Add Delegated Instructor
☐ Remove Program Director and/or Delegated Instructor – Name: _____

☐ Report change of ownership or vested partnership – Name:
_____

Name of Entity:_____

Doing Business As (d/b/a): _____

Street Address:_____

PO Box Number:_____

City:_____State:_____

ZIP code:_____ Telephone number:_____ Fax number:_____

E-mail address: _____

Owner's name: _____

Owner's company name *(if applicable)*: _____

Names of all officers, principals and/or vested partners: _____

_____

_____

_____

For each officer, principal and/or vested partner, specify the name and the years of operation of any and all previous nurse aide training programs with which the officer, principal and/or vested partner has been or currently is associated:

_____

_____

Location of CLASSROOM TRAINING *(if different from above address)*:

Name:_____

Address:_____

City:_____State:_____

ZIP code:_____ Telephone number:_____

SECTION B: Clinical Site(s) information

Name of Facility:_____

Address:_____

City:_____State:_____ZIP code:_____

Name of Facility:_____

Address:_____

City:_____State:_____ZIP code:_____

Name of Facility:_____

Address:_____

City:_____State:_____ZIP code:_____

Name of Facility:_____

Address:_____

City:_____State:_____ZIP code:_____

SECTION C: Program Director and/or Delegated Instructor information

Name:_____

Nursing License Number:_____ Vocational License Number:_____

If this is a facility based program – is the Program Director also the Director of Nursing?

☐ Yes ☐ No

A copy of the license MUST accompany this application.

QUALIFICATIONS: PLEASE PROVIDE SPECIFIC DATES AND LOCATIONS FOR THE FOLLOWING:

NURSING EXPERIENCE:

LONG TERM CARE EXPERIENCE – MUST INCLUDE SPECIFIC DATES AND LOCATIONS:

TEACHING EXPERIENCE:

A COPY OF THE C.N.A. TRAIN-THE-TRAINER COURSE CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

SECTION D: Certification of program

I certify that the Nurse Aide Training Program will be conducted in accordance with 410 IAC 16.2-3.1-14, 42 USC §1395i-3, 42 CFR §1396r, 42 CFR 483.75, 42 CFR 483.150 through 42 CFR 483.160, the Core Curriculum for the Indiana Nurse Aide Training Program, and any other standards for Nurse Aide Training programs established by the Indiana Department of Health. I certify that adequate records will be maintained and made available to IDOH surveyors in order to determine compliance with those standards. I certify that the administrator of this program as well as other personnel (including owners, officers, principals and vested partners) have never been subject to a revocation of approval of a Nurse Aide Training Program. I also certify that all facilities listed on this application do not have a current ban on nurse aide training.

_____ _____

Administrator of facility OR Director of non-facility based program Date *(month, day, year)*