



**APPLICATION FOR APPROVAL TO OPERATE
A NURSE AIDE OR A QUALIFIED MEDICATION AIDE TRAINING PROGRAM**

State Form 629 (R8 / 1-26)
INDIANA DEPARTMENT OF HEALTH
CONSUMER SERVICES AND HEALTH CARE REGULATION

- INSTRUCTIONS:** *This original application **MUST** be available upon request and/or at time of survey.
 - Submit this application and additional required documentation electronically to aidetraining@health.in.gov
 - **Submit a separate application for each type of program requesting approval or change.** (i.e. 1 for NAT requests and 1 for QMAT requests)

<p>SECTION 1: Program Information</p> <p>Program Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Email Address: _____ Phone: _____ Name & Title of Contact Person #1: _____ Contact Person Phone & Email: _____ Name & Title of Contact Person #2: _____ Contact Person Phone & Email: _____ Owner's Name: _____ Owner's Email: _____ Owner's Phone: _____</p> <p>Please, immediately submit any changes to the information above to aidetraining@health.in.gov</p>	<p>IDOH Use only</p> <p><input type="checkbox"/> Approved <input type="checkbox"/> Not Approved</p>
<p>SECTION 2: Program Approval or Renewal Request</p> <p>REQUEST for: <input type="checkbox"/> NAT <input type="checkbox"/> QMAT</p> <p>You must submit a SEPARATE application for each type of program requesting approval or change.</p> <p>If you are requesting approval for a QMA training program, will you offer the Insulin Administration Education Module? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable</p> <p><input type="checkbox"/> Initial Approval <input type="checkbox"/> Renewal</p> <p>Program Type: <input type="checkbox"/> Facility Based <input type="checkbox"/> Non-facility Based <input type="checkbox"/> Vocational/Academic <input type="checkbox"/> Other: _____</p> <p>Training Modality: <input type="checkbox"/> Traditional Classroom <input type="checkbox"/> Hybrid – Online <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Change(s) to Current Approved Program</p> <p>Program Changes: <input type="checkbox"/> Classroom <input type="checkbox"/> Clinical Sites <input type="checkbox"/> Curriculum/Modality <input type="checkbox"/> Address <input type="checkbox"/> Program Director/Instructor <input type="checkbox"/> Ownership <input type="checkbox"/> Name</p>	<p>IDOH Use only</p> <p>Facility #:</p> <p>NATCEP ban dates: N/A: _____ Exp: _____</p>
<p>SECTION 3: Classroom Location (See Section 7 for Additional Required Documents)</p> <p><input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Information change</p> <p>Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____</p> <p><input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Information change</p> <p>Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____</p>	<p>IDOH Use only</p> <p><input type="checkbox"/> Approved <input type="checkbox"/> Not Approved</p> <p><input type="checkbox"/> Approved <input type="checkbox"/> Not Approved</p>

SECTION 4: Clinical Site (if needed, use additional copies of this page)

IDOH Use only

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

Add Delete Information change

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Approved
 Not Approved

SECTION 5: Program Director (PD) /Delegated Instructor (DI) /Program Instructor (PI)

IDOH Use only

Note: In order to initiate the application review process to add a NAT Program Director (must be an RN), a NAT Delegated Instructor (must be an RN or an LPN,) or a QMA Program Instructor (can be RN or LPN), the following **MUST** be submitted at the same time as this application.

- Copy of nursing license
- Copy of vocational license, or equivalent, if applicable
- Copy of Certified Nurse Aide or Qualified Medication Aide Instructor Train the Trainer Course Certificate
- Brief resume of long-term care and teaching experience, including locations and dates

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

Add Delete (Facility based program only – Director of Nursing Yes No)

Name: _____ PD DI PI

Approved
 Not Approved

SECTION 6: Curriculum

IDOH Use only

Curriculum: Add Delete
Explanation of Change:

Approved
 Not Approved

Curriculum: Add Delete
Explanation of Change:

Approved
 Not Approved

SECTION 7: Additional Required Documentation

IDOH Use only

Initial Approval of NAT Program:

To initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Pictures of classroom & clinical lab with supplies/equipment – (2-3 pictures each)
2. Copy of sample clinical agreement
3. Form(s) for classroom time record and clinical time record
4. Certificate of completion for the student – must state student's name "has successfully completed the Indiana State Department of Health approved Nurse Aide Training Program," must have area for signature and date of program director and must have name and address of training entity.
5. List of items that will be kept in the student file
6. Final exam – comprehensive with all lessons
7. Signed and dated supply list
8. Outline of classroom lesson plan with day, timeframes, and content to be completed, including Core Curriculum lessons, RCPs, videos, YouTube, textbooks, handouts, and any other resources.
9. Student pre-admission math/reading assessment/test
10. Copy of the Train the Trainer certificate of completion and nursing license for each program director and/or instructor

Approved - A
Not Approved
- NA

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Initial Approval of QMAT Program:

To initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Letter indicating the IDOH QMA curriculum will be followed or a copy of the program specific lesson plans
2. Supply list (signed and dated) indicating all supplies are available.
3. List of items that will be included in each student file
4. Copy of classroom time record for each student
5. Copy of clinical site agreements – NOTE: All QMA training sites MUST have clinical site approval for every clinical site used by students.
6. Picture of current drug book that will be given to each student to keep
7. Pictures of classroom and Medication cart with medications (2-3 pictures each)
8. Copy of the Train the Trainer certificate of completion and nursing license for each program director and/or instructor

Approved - A
Not Approved
- NA

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Addition of Classroom: In order to initiate the application review process, the following information MUST be submitted at the same time as this application.

1. Letter stating the new classroom site will:
 - A. Use the approved training curriculum and
 - B. All the necessary supplies and equipment are available
2. Pictures of classroom and clinical lab (2-3 pictures of each.)

Approved - A
Not Approved
- NA

- 1-A. _____
- 1-B. _____
2. _____

SECTION 8: Certification of NAT Program	IDOH Use only
<p>I certify that the Nurse Aide Training Program will be conducted in accordance with 410 IAC 16.2-3.1- 14, IC 16-27.5-3, 42 USC 1395i-3, 42 USC 1396r, 42 CFR 483.150 through 42 CFR 483.160, the Core Curriculum for the Indiana Nurse Aide Training Program, CMS State Operations Manual, Chapter 4, 4132, and any other standards for Nurse Aide Training programs established by the Indiana Department of Health or the Certified Health Care Professions Commission. 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 all facilities listed on this application do not have a current ban on nurse aide training.</p> <p>_____ Signature of facility Administrator OR Director of non-facility-based program</p> <p>_____ Date (month, day, year)</p>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
SECTION 9: Certification of QMAT Program	IDOH Use only
<p>I certify the Qualified Medication Aide Training Program will be conducted in accordance with IC 16-27.5-4, the Indiana Administrative Code requirements for QMA Training, the Core Curriculum for Indiana QMA Training Programs, and any other standards for QMA Training Programs established by the Indiana Department of Health or the Certified Health Care Professions Commission. I certify adequate records will be maintained and made available to IDOH surveyors, in order to determine compliance with those standards. I certify 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 Qualified Medication Aide Training Program.</p> <p>_____ Signature of facility Administrator OR Director of non-facility-based program</p> <p>_____ Date (month, day, year)</p>	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
<p>Explanation of Minimum Requirement(s) Not Met:</p> <p>_____</p> <p>NOTES:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	