Reset Form

APPLICATION FOR APPROVAL OF A DINING ASSISTANT TRAINING PROGRAM

State Form 54667 (R / 7-23)
Indiana Department of Health – Consumer Services & Health Care Regulation

INDIANA DEPARTMENT OF HEALTH
Consumer Services & Health Care Regulation
2 North Meridian Street, 4B
Indianapolis, IN 46204

INSTRUCTIONS: 1. Email the completed application, along with all requested documentation, to IDOHLTCTrainingprograms@health.in.gov.
a. Copy of Qualified Instructor's Nursing License
b. Copy of Qualified Instructor's Train the Trainer Certificate
c. Copy of all additional instructor's professional license (if applicable)
d. Copy of all additional instructor's Train the Trainer Certificate (if applicable)
e. Copy of the curriculum, if not using IDOH curriculum (see details below)
f. Class Plan for the training program (see details below)
2. Save a copy of this application for your records.
3. Submit an updated form for approval for all program changes prior to the change taking place.

SECTION A: TRAINING PROGRAM INFORMATION

Name of Facility:_____

Address:_____

City:_____State:_____

ZIP code:_____ Phone:_____ Fax number:_____

Name & Title of Contact Person #1:_____

Contact Person Email:_____ Phone:_____

Name & Title of Contact Person #2:_____

Contact Person Email:_____ Phone:_____

Curriculum to be used for Training Program (IDOH or Other) _____
If using curriculum other than the IDOH Dining Assistant Training Program Curriculum, it must follow the IDOH curriculum and must be submitted for approval along with this application.

Class Plan for Training Program:
This course must be at least 16 hours in length (8 classroom and 8 clinical). Submit a breakdown of number the of days, hours per day, what will be covered during each session, etc.

If this form is being submitted for updates to an existing training program, please give a brief description of the requested changes.

_____
_____
_____
_____

SECTION B: QUALIFIED INSTRUCTOR INFORMATION

The Qualified Instructor is responsible for the program and at a minimum must:
1. Possess a valid Indiana registered nurse license under IC 25-23-1-1.
2. Possess at least 2 years of licensed nursing experience, of which at least 1 year of experience is in the provision of long-term care.
3. Completed a department approved training program.

Name:_____

Nursing License Number:_____

Email Address:_____ Phone:_____

PLEASE PROVIDE SPECIFIC DATES & LOCATIONS FOR THE FOLLOWING REQUIRED QUALIFICATIONS:

NURSING EXPERIENCE:

_____
_____
_____
_____
_____

LONG TERM CARE EXPERIENCE:

_____
_____
_____
_____
_____

TEACHING EXPERIENCE:

_____
_____
_____
_____
_____

Information for Additional Instructors:

Name and Title:_____

Name and Title:_____

Name and Title:_____

SECTION C: CERTIFICATION OF PROGRAM

I certify the Dining Assistant Training Program will be conducted in accordance with the federal and state regulations.

_____ _____

Administrator of facility *(typed name is acceptable)* Date *(month, day, year)*