The following information must be included with your initial application before the approval process to become a nurse ide training program can be completed. We will not process the application unless all the information is submitted for review. Please return the information to:

Linda Kellen, Jennifer Larson
Department of Inspections and Appeals
Lucas State Office Building – Health Facilities Division
321 East 12th Street
Des Moines, IA 5319

1. A signed and completed program application (State form 427-0517).

2. Documentation of the work experience and education of the program coordinator and program instructors. **State Rule 81.16(3)a(5)1-5.**

3. A course syllabus/lesson plan serves as the plan for the course and guides the student in their class preparation. Develop a syllabus/lesson plan for EACH day of class which includes the following information:

   a. Total hours spent in class each day (exclusive of coffee and lunch breaks). **State Rule 81.16(3)a(3)** requires 75 hours of training that includes 30 hours of clinical, 30 hours of classroom and 15 hours of laboratory time. Indicate what experience will occur on each day, such as class and lab time or clinical time.
   b. Curriculum objectives/content from the approved curriculum to be covered (Note: The textbook is not considered to be the approved curriculum). **State Rule 81.16(3)e(4) & 81.16(3)b**
   c. Textbook reading assignments.
   d. Quizzes.
   e. Clinical skills to be demonstrated.
   f. Other instructional materials used as a part of the course.

4. Program policies and procedures that, at a minimum, include:

   a. Criteria for successful completion of the course. **81.16(3)a(6)**
   b. Attendance procedures and policies.
   c. Policy for records to be maintained for each class and student (Maintain attendance records, course certificates, skill performance records, course syllabus, course evaluations and, if performing competency testing, testing information).
   d. Policy for the documentation given to students successfully completing the course. State **Rule 81.16(3)e(5)** (Please indicate your program approval number on course certificates once you have received program approval).
   e. Policy for instructor to student ratio in the clinical experience. **State Rule 81.16(3)a(5)5**
   f. Policy for how students will be informed of skills found proficient to perform. **State Rule 81.16(3)e(3)**
   g. Procedures for notifying the department of substantive changes in the program and notification of class offerings. **State Rule 81.16(3)e(1)1-3**
   h. Policies for program coordinator and program instructor qualifications and ongoing performance evaluation. **State Rule 81.16(3)a(5)1-5**
   i. Policy indicating when and under what circumstances untrained aides will be allowed floor assignments on days they are not in class and how proficiency in resident care skills is to be communicated to the employing facility staff. Indicate specifically what course information must be covered prior to any resident contact and prior to any floor assignments. **State Rule 81.16(3)a(3) & (4) and 81.16(3)b(1)1-5**
   j. Policies and procedures for collecting/refunding course fees from student not employed by the facility. **81.16(3)c(2)**

k. Policies and procedure for not charging and collecting fees from a student employed by a certified long term care facility or who has an offer of employment. Policies and procedures for repayment for course test fees for students who become employedby the facility within one year of completing the course/test. **State Rule 81.16(3)c, d, e, f, g**

l. Policies and procedures for proctoring and administration of the nurse aide competency evaluation, when applicable. **State Rule 81.16(4)d**

m. Procedures for notifying the nurse aide competency testing entity of students eligible to be tested.

n. Policies and procedures for evaluating student performance andinstructor effectiveness. **81.16(3)a(6)**

5. Written information given to the student that includes:

a. Information on the nurse aide competency evaluation to include the components of the test (written and skills testing), option of taking the written test orally, number of opportunities to take each portion of the test, passing score, reporting of the scores to the nurse aide registry and retraining/retesting if test is failed after threeattempts. **State Rule 81.16(4)**

b. Information included on the nurse aide registry and the requirement for continued employment and registration of founded abuse allegations. **State Rule 81.16(5)** Information on the program's attendance and successful completioncriteria.

c. Description of course content and expected objectives and performancestandards.

For questions relating to information requested, contact Linda Kellen at (515) 281-4245.

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS | HEALTH FACILITIES DIVISION
NURSE AIDE TRAINING PROGRAM APPLICATION

☐ Initial Application ☐ Renewal ☐ Training Site Change

Applicant Organization	Street Address	Program Number
City/State	Zip	Phone ( )
Website Address	FAX Number	Email Address
Program Coordinator	Curriculum Title	Date of Development/Revision

PHYSICAL FACILITIES: **The information requested below refers to all possible locations for classroom and clinical training.**
Note: State Regulations require that classrooms have adequate space for students, adequate lighting, temperature controls, and equipment to stimulate resident care situations and audio-visual equipment as needed. Classrooms/labs cannot be in areas routinely used by residents. Training is prohibited in any facility subjected to denial of nurse aide training for a two-year period.

LOCATION - CLASSROOM

Building: Street Address: City/State/Zip: Room Name or #:		Building: Street Address: City/State/Zip: Room Name or #:	
Building: Street Address: City/State/Zip: Room Name or #:		Building: Street Address: City/State/Zip: Room Name or #:	
Building: Street Address: City/State/Zip: Room Name or #:		Building: Street Address: City/State/Zip: Room Name or #:	

LOCATION – CLINICAL TRAINING

Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	
Facility Name: Street Address: City/State/Zip:		Facility Name: Street Address: City/State/Zip:	

Check off all resident care equipment available for classroom use below:

	Over the bed table			**Bed and linens**			**Privacy Curtain**
	Catheter/Drainage bags			**Wheelchair**			**Wash basin & emesis basins**
	Gait belts			**Stethoscope**			**Towels & washcloths**
	Bedpan			**Sphygmomanometer**			**Hand hygiene facilities**
	Urinal			**Thermometers**			**Call light**

Textbooks Used:

Nursing Assistant Care The Basics |Hartman Publishing, INC| with Jetta Fuzy, MS, RN |Sixth Edition
Workbook Harman's Nursing Assistant Care The Basics |Sixth Edition
How to be a Nursing Assistant |Training Solutions for Quality Care | Eight Edition

Competency Testing Entity Used:

Name of Program Coordinator		**RN License Number**	**Work Experience: Has the Supervising RN had at least <u>two years of nursing experience</u> with at least <u>one year in provision of long-term care facility services</u>?**	
			☐ Yes	☐ **No**
Name(s) of Instructors		**RN License Number**	**Work Experience: Have the instructors had at least <u>two years of nursing experience</u> with at least <u>one year in provision of long-term care facility services</u>?**	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Name of Program Coordinator		RN License Number	Work Experience: Has the Supervising RN had at least <u>two years of nursing experience</u> with at least <u>one year in provision of long-term care facility services</u>?	
			☐ Yes	☐ **No**
Name(s) of Instructors		**RN License Number**	**Work Experience: Have the instructors had at least <u>two years of nursing experience</u> with at least <u>one year in provision of long-term care facility services</u>?**	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

COMMENTS:

_____ _____

Program Coordinator Signature **Date:**

_____ _____

Administrator's Signature **Date:**