THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Nurse Aide Registry
550 West 7th Avenue, Suite 1500, Anchorage, AK 99501
(907) 269-8161
Email: *BoardofNursing@Alaska.Gov*
Website: *Nursing.Alaska.Gov*

NUA

FOR DIVISION USE ONLY

Nurse Aide Training Program Application

PART I Payment of Fees

Fee:	☐ Application Fee *Enclose check or money order made payable to the State of Alaska.*	**$500.00**

PART II Point of Contact

Name/Title:	
Address:	
Phone Number:	
Contact Phone:	

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		☐ **Send my Correspondence by Email** ☐ **Send my Correspondence by US Mail**

PART III Facility Information

Please select the applicable facility type:

☐ **Facility Based Program** ☐ **Non-Facility Based Program**

PART IV Program Information

Program Name:	
Physical Address:	
Mailing Address:	
Contact Phone:	
Fax Number:	
Program Length: *(clocked hours)*	***Min. of 60 hrs. classroom/80 hrs. clinical (32 lab/practice & 48 facility clinical) experience required by the State of Alaska.***
	Classroom: _____ Clinical Lab/Practice: _____ Facility: _____
Projected date of first offering:	
Number of projected offers over the next two years:	
Name of Clinical Site:	
Address of Clinical Site:	
Name of Agency/Facility:	
Address of Agency/Facility:	
NON-FACILITY ONLY: ☐ **I have attached a copy of the contractual agreement signed by program and facility.**	

PART V Student Eligibility

Eligibility: *(check one)*	☐ **Open to all** ☐ **Restricted to (specify):_____** ☐ **Restricted to agency/facility employees**		
Greatest number of applicants anticipated in each program offering:			
Faculty/Student Ratio: Classroom max ratio 20 students to 1 instructor/Clinical - 10 students to 1 instructor			
Classroom:		**Clinical:**	

PART VI Faculty & Instructors

List names and RN/LPN license #'s for each instructor candidate, including the Director of Nurses (for facility-based programs):
Attach more pages is necessary. See 12 AAC 44.840 for program instructor(s) qualifications.

Name:		**RN License Number:**	
Name:		**RN License Number:**	
Name:		**RN License Number:**	
Name:		**LPN License Number:**	

PART VII Required Materials

Please send the following materials with this application for review and consideration regarding training program approval per 12 AAC 44.830.

By checking the appropriate boxes below, you are verifying you have included the following material:

☐ **$500.00 Application Fee**
Check or money order payable to the State of Alaska.

☐ **Resumes of Faculty and Instructors**
Resumes of faculty and instructors showing qualifications

☐ **Program Summary**
Summary of rationale, philosophy and purpose of the program

☐ **Program Outline**
Program outline including the program's title, objectives, content, and teaching methodology including:

- Schedule/calendar of classroom topics and number of classroom hours, clinical instruction hours, which includes supervised skills and clinical instruction hours
- Copy of curriculum, name of textbook/workbook and any other instructional materials
- Description of classroom, classroom clinical lab, and clinical facilities

☐ **Final Evaluations**
Final classroom and clinical competency evaluation including:

- Copy of skills checklist, used to measure student clinical skills, including date each skill performed, marked as satisfactory or unsatisfactory, signature of instructor 12 AAC 44.852;
- Sample of student record used for documenting clinical and didactic hours
- Copy of the final exam

☐ **Clinical Facility Agreement(s) - *If applicable***
Send in with application or state status of the agreement. Must be submitted prior to application review by the Board.

Are you willing to be a contact for others who are developing a similar program? ☐ **YES** ☐ **NO**

Have you applied for postsecondary education approval? ☐ **YES** ☐ **NO**

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Signature Page

Applicant Name:	

PART VIII Agreement

I hereby certify that I am the person herein named and subscribing to this application and that I have read the complete application, and I know the full content thereof. I declare that all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, certificate, or permit to practice in the state of Alaska.

I further understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

Applicant's Signature:		**Date:**	

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State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Program Type: _____ License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(name change, wall certificate, fine, duplicate license, exam, etc.)*:
  1. _____ _____
  2. _____ _____

TOTAL: 0

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: _____

08-4438 Rev 12/26/18 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: _____
2. Expiration Date: _____
3. Security Code: _____

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.