



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

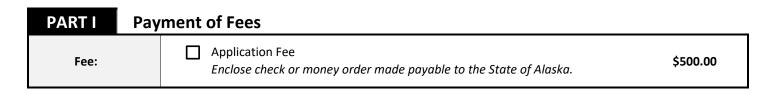
#### **Nurse Aide Registry**

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

#### FOR DIVISION USE ONLY

NUA

# **Nurse Aide Training Program Application**



PART II Point	t 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 fa	cility type:		
Facility Based Program	Non-Facility Based Program		

# PART IV Program Information

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

PART V	Stu	dent Eligibilit	ty		
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
- $\circ$  Copy of curriculum, name of textbook/workbook and any other instructional materials
- Description of classroom, classroom clinical lab, and clinical facilities

#### **Final Evaluations**

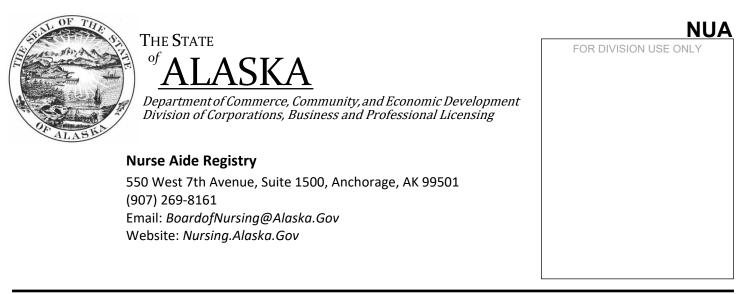
Final classroom and clinical competency evaluation including:

- 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	
Have you applied for postsecondary education approval?	YES	



## **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:



### THE STATE of ASKA

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

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 Applica	ant or Licensee:		
Program Type:		License Number ( <i>if applicable</i> ): _	
I wish to make p	ayment by credit card for	r the following (check all that apply):	AMOUNT
Applicatio	on Fee:		
License c	or Renewal Fee:		
Other (na	me change, wall certifica	ate, fine, duplicate license, exam, etc.):	
1			
2			
		TOTAL:	
Name (as shown	n on credit card):		
Mailing Address	:		
Phone Number:		Email <i>(optional)</i> :	
Signature of Cr	edit 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:	 r

All 3 fields MUST be completed!

This section will be destroyed after the payment is processed.