

FACULTY REQUIREMENTS

All Nurse Aide I Training (NAT) Faculty must meet the criteria as specified below. Please use the information to evaluate potential faculty. Complete the **Faculty Approval Request Form** that follows for each member of your nurse aide faculty. To remove faculty please use form # DHHS/DHSR/HCPR-4512. This form can be found on our website: www.ncnar.org.

PROGRAM COORDINATOR

REQUIREMENTS
1. The applicant is a registered nurse with an unencumbered license.
2. The applicant is licensed to practice in North Carolina.
3. The applicant has at least two (2) years of experience as a registered nurse.
4. The applicant has at least one (1) year (2000 hours) of RN experience in the provision of long term care facility services demonstrated by: a. working in a long term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital, or b. supervising or teaching students in a long term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital.

PRIMARY OR ADDITIONAL INSTRUCTOR

REQUIREMENTS
1. The applicant is a registered nurse with an unencumbered license.
2. The applicant is licensed to practice in North Carolina.
3. The applicant has at least 2 years of experience as a registered nurse.
4. The applicant meets at least one of the following: a. completion of a course in teaching adults, b. experience in teaching adults, or c. experience in supervising nurse aides.

FACULTY APPROVAL REQUEST FORM FOR NURSE AIDE I TRAINING PROGRAM

School/Facility:		
Street:		
City:	County:	Zip Code:
Area Code, Telephone Number & Direct Extension:		
Fax Line:	E-Mail Address:	

Nurse Aide Training Program Number(s) (NAT Only):

√	Position(s) Requested (Please check box)	Applicant's Name as it appears on RN License (Please Print Name)
<input type="checkbox"/>	Program Coordinator	First:
<input type="checkbox"/>	Primary Instructor	Middle:
<input type="checkbox"/>	Additional Instructor	Last :

RN License #: _____		<input type="checkbox"/> N.C. License	<input type="checkbox"/> Compact State License
<input type="checkbox"/> Specify state: _____	<input type="checkbox"/> Permanent or <input type="checkbox"/> Temporary (*Note: If temporary NC RN # is assigned, DHSR must be notified when permanent NC RN license # is issued)	License Expiration Date: _____	
		RN License in Good Standing: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Original RN Licensure (Month/Year): _____		State of Original Licensure: _____	
N.C. Board of Nursing Confirmation # _____		Date: _____	

I certify that the information in this application is correct and accurate to the best of my knowledge and that the minimum requirements for the position(s) requested have been met.

Signature: _____
Applicant

Date: _____

Signature: _____
Nurse Aide I Program Coordinator/Administrator/Director of Nursing

Date: _____

Printed: _____
Nurse Aide I Program Coordinator/Administrator/Director of Nursing

Name of Applicant: _____

I. NURSING EDUCATION

Name of College/University/School of Nursing:	
Street Address:	
City/State/Zip Code:	
Indicate Highest Educational Level: <input type="checkbox"/> ADN <input type="checkbox"/> Diploma <input type="checkbox"/> BS <input type="checkbox"/> MSN <input type="checkbox"/> Other	

II. OTHER EDUCATION

College/University:	
Discipline:	Degree:

PLEASE INCLUDE RN EXPERIENCE THAT DEMONSTRATES CRITERIA ONLY

III. REGISTERED NURSING EMPLOYMENT HISTORY

Dates: From:		To:		
(Month/Day/Year)		(Month/Day/Year)		
Facility:		Position:		
Type of Facility:		<input type="checkbox"/> Full time		
Address:		<input type="checkbox"/> Part time: _____ (# of hours)		
City/State/Zip:				
Area Code/Phone:				
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Med/Surg	<input type="checkbox"/> Hospital SNF	<input type="checkbox"/> Home Health/Hospice
<input type="checkbox"/> Swing Bed Unit	<input type="checkbox"/> Supervised NAs as part of job		<input type="checkbox"/> Cared for chronically ill or elderly	
<input type="checkbox"/> Other (specify)				

Dates: From:		To:		
(Month/Day/Year)		(Month/Day/Year)		
Facility:		Position:		
Type of Facility:		<input type="checkbox"/> Full time		
Address:		<input type="checkbox"/> Part time: _____ (# of hours)		
City/State/Zip:				
Area Code/Phone:				
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Med/Surg	<input type="checkbox"/> Hospital SNF	<input type="checkbox"/> Home Health/Hospice
<input type="checkbox"/> Swing Bed Unit	<input type="checkbox"/> Supervised NAs as part of job		<input type="checkbox"/> Cared for chronically ill or elderly	
<input type="checkbox"/> Other (specify)				

Name of Applicant: _____

REGISTERED NURSING EMPLOYMENT HISTORY CON'T.

Dates: From:		To:		
(Month/Day/Year)		(Month/Day/Year)		
Facility:		Position:		
Type of Facility:		<input type="checkbox"/> Full time		
Address:		<input type="checkbox"/> Part time: _____ (# of hours)		
City/State/Zip:				
Area Code/Phone:				
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Med/Surg	<input type="checkbox"/> Hospital SNF	<input type="checkbox"/> Home Health/Hospice
<input type="checkbox"/> Swing Bed Unit	<input type="checkbox"/> Supervised NAs as part of job		<input type="checkbox"/> Cared for chronically ill or elderly	
<input type="checkbox"/> Other (specify)				

IV. ADULT TEACHING EXPERIENCE

Dates: From:		To:	
(Month/Day/Year)		(Month/Day/Year)	
Facility:		Describe teaching experience:	
Address:			
City/State/Zip:			
Area Code/Phone:			

Dates: From:		To:	
(Month/Day/Year)		(Month/Day/Year)	
Facility:		Describe teaching experience:	
Address:			
City/State/Zip:			
Area Code/Phone:			

V. TEACHING METHODOLOGY COURSE

Sponsored by:	
Address:	
Course content:	Date completed:

VI. ADDITIONAL INFORMATION YOU MAY WANT CONSIDERED RELATED TO THE REQUIREMENTS:

Complete and return to the address above or e-mail (pdf only) to: brenda.sanders@dhhs.nc.gov.