

**GERIATRIC AIDE TRAINING PROGRAM FOR REGISTRY LISTING
COMMUNITY COLLEGE APPROVAL APPLICATION**

Community College Name:	
Mailing Address:	Area Code/Telephone Number:
	Area Code/Fax Number:
Site Address:	E-mail address:

Note: Please complete all appropriate blanks. Incomplete forms will be returned.

<p>REQUIRED HOURS: No. of Classroom Hours = 75 No. of Clinical Hours = 25 Total Hours = 100</p> <p>Specify Curriculum Type: <input type="checkbox"/> Continuing Education <input type="checkbox"/> Curriculum</p>
--

STATEMENT OF UNDERSTANDING

- I understand that approval to offer this program is based on our agency using the state-approved geriatric aide curriculum. I understand that I must teach, at a minimum, 75 hours of content, to include all modules as written in the curriculum, and provide 25 hours of clinical as directed. I understand that students must be listed on the Nurse Aide I Registry prior to attending the course. I further understand our agency may be required to make modifications to this program as requested by North Carolina Division of Health Service Regulation (DHSR). Modifications made by the state to the state-approved curriculum and provided to our agency will be incorporated into the currently approved program under which our agency operates.
- I understand that a college must require a minimum numerical grade of 75 as the final theory grade.
- I understand that changes in faculty or clinical sites must be approved by the DHSR prior to implementation.
- I understand DHSR may withdraw approval of this training program if it determines that the program does not meet state requirements.
- I certify that class rosters with records of successful completion of the course will be made available to DHSR upon request.

Signature of Program Coordinator

Date

Signature of Administrator

Date

FOR OFFICE USE ONLY - DO NOT WRITE IN THIS BOX

Program # Assigned _____	Continuing Education _____	Curriculum _____
EFFECTIVE APPROVAL DATE _____		
ADDITIONAL INFORMATION:		
DHSR STAFF SIGNATURE _____	DATE _____	

CLINICAL SITES

Clinical Site #1

Name: _____

Address: _____

Telephone Number: () _____

Clinical Site #2

Name: _____

Address: _____

Telephone Number: () _____

Clinical Site #3

Name: _____

Address: _____

Telephone Number: () _____

Attach an additional sheet with the above information if you have more than three (3) clinical sites.

FACULTY: (Faculty Approval Request forms can be found at www.ncnar.org)

Program Coordinator: _____ **RN Certificate Number** _____

Previously approved as NAI program coordinator **OR** Faculty approval form is attached.

Instructor: _____ **RN Certificate Number** _____

Previously approved as NAI instructor **OR** Faculty approval form is attached.

Instructor: _____ **RN Certificate Number** _____

Previously approved as NAI instructor **OR** Faculty approval form is attached.

Instructor: _____ **RN Certificate Number** _____

Previously approved as NAI instructor **OR** Faculty approval form is attached.

COMPLETING THE APPLICATION PROCESS:

Please fax your application to 919-733-9764. If you prefer to mail your application, please use the following address:

Brenda Sanders, Education Support Coordinator
NC Department of Health and Human Services
Division of Health Service Regulation, Center for Aide Regulation and Education
2709 Mail Service Center, Raleigh, NC 27699-2709

Please contact Ms. Sanders at (919) 855-3970 if you need further information.