

FOR OFFICE USE ONLY

Date Received

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Issue Date

License #



Rhode Island Department of Health

Room 103

3 Capitol Hill

Providence, RI 02908-5097

Instructions and License Application for

License As A Nursing Assistant Training Program

OFFICE USE ONLY

DO NOT REMOVE THIS PAGE FROM APPLICATION

Applicant - Print Name (Full Name)

Phone: (401) 222-5888

TTY/TDD: (800) 745-5555

Fax: (401) 222-3352

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays. If you have any questions concerning this application, call the office of Health Professions at (401) 222-5888.

Approval of training programs shall be granted after the application has been reviewed for document compliance, reviewed by the Nursing Assistant Advisory Board, and a site survey has been conducted to ensure operational compliance.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. Make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages. You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **\$325.00** payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
3. Complete all application materials as instructed. Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

**Rhode Island Department of Health
Room 103, 3 Capitol Hill
Providence, RI 02908-5097**

Rules and Regulations/Laws

The "Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Medication Aides and the Approval of Medication Aide Training Programs" can be obtained at the following web site:

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7008.pdf>

Rhode Island General Laws can be downloaded at the following web site:

<http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm>

6. Ownership Information:

Provide the name address and telephone number(s) of the facility/business owner in the spaces provided.

Name of Owner																								
D.B.A. (Doing Business As)																								
First Line Address																								
Second Line Address																								
Third Line Address																								
City										State/Province					Zip Code									
Country, If NOT U.S.																								
Facility Phone					Extension					Facility Fax														
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																								
U.S. Social Security Number (SSN)										<p>“Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN)//Federal Employer Identification Number (FEIN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.”</p>														
Federal Employer Identification Number (FEIN)																								

NOTE: If you are the sole proprietor of a facility or business, then you must supply your Social Security Number (SSN). If you are an individual representing a facility or a business that is seeking licensure, then you must supply the Federal Employer Identification Number (FEIN) for the facility or the business.

7. Nursing Facility/ Hospital:

State licensure regulations require that your clinical training program be affiliated with a nursing facility or hospital. Please provide the name and RI License Number of the Nursing Facility or Hospital

Facility/Hospital Name																								
RI License Number																								

8. Program Coordinator:

Please provide the information for the program coordinator.

NOTE: Program Coordinators must be licensed RN's with at least 2 years of nursing experience.

First Name																								
Last Name																								
Contact Phone					Extension					Contact Fax Number														
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)																								
RI RN License Number																								

Please provide a copy of your current resume.

9. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this license to practice in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Division of Taxation.

Signature of Authorized Person

Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary



Notary No/Commission No.

Commission Expiration Date (MM/DD/YY)

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- A \$325.00 non-refundable check or money order made payable to ***Rhode Island General Treasurer*** ;
- A completed and notarized application;
- Evidence of support and fiscal administration accountability;
- Proof of adequate resources/facilities, including locations of potential students, faculty, classrooms, conference rooms, and clinical laboratory for practical experience;
- Names and qualifications of instructors;
- A copy of the curriculum including provisions for the practical experience (must be consistent with the curriculum outline of Appendix II of the *Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants, Medication Aides, and the Approval of Nursing Assistant and Medication Aide Training Programs*. ****See Rules and Regulations at the following website for the Standards for Nursing Assistant Training Program Approval;***

<http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7060.pdf>
- Title, publication date, and edition of textbooks/workbooks to be utilized by students enrolled in the program.
- A systematic plan for on-going evaluation of the curriculum;
- Written statements of purpose, philosophy and objectives of the program;
- An organizational chart showing the relationships and channels of communication of the program to other agencies (with clearly defined authorities/responsibilities);
- A list of practical experiences related to areas of instruction of the didactic segment of the program;
- Written policies and procedures pertaining to the nursing assistant training program including:
 - a) admission, re-admission, retention, dismissal and course completion requirements
 - b) the identification of the resource facilities for the practical experience in a long-term care or appropriate acute care facility;
 - c) the supervision requirement of nursing assistants in all settings:

**** PLEASE NOTE: Applications must be completed within one year or a new application and fee must be submitted.**

CERTIFIED NURSING ASSISTANT TRAINING EQUIPMENT LIST

MOBILITY

Tables/desks/chairs	Shower benches
Projectors (computer/overhead + screen TV/VCR/DVD)	Bed linens
Books	Canes (Standard, quad)
Hospital Bed	Crutches
Mannequin	Walker (wheeled and non-wheeled)
Wheelchair	Side board
Hoyer Lift (Note: other lifts used at facility)	Gait Belt

PPE

Disposable Gloves	Gowns (disposable + cloth)
Masks (surgical + HEPA)	Googles/Eye Protection
Shoe Covers	

PERSONAL CARE + GROOMING

Basins (Wash + Emesis)	Disposable washclothes
Briefs	Orangewood Sticks
Emery Boards	Oral Swabs
Toothbrushes + toothpaste	Dentures (2 sets)
Elastic Stockings	Clothing

NUTRITION/ELIMINATION

Tray/Feeding set up	Commercial Enema
Ostomy Demo/Supplies	Bedpans (standard + fx)
Urinal	Foley + Condom Catheters (drainage Bags incl)
Leg Bag	Enema
Graduates	Specimen Containers

VITAL SIGNS

BP Cuffs	Teaching Stethoscopes
Thermometers	

ADDITIONAL

Abdominal and Breast Binders