FOR OFFICE USE ONLY

Date Received

Receipt #

ID #

Issue Date

License #

OFFICE USE ONLY

Rhode Island Departement of Health

Room 103
3 Capitol Hill
Providence, RI 02908-5097

Instructions and
License Application for

License As A
Nursing Assistant Training Program

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**

Revised 06/24/2016 jcp

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

State of Rhode Island

Application for Nursing Assistant Training Program

Type or block print only. Do not use felt-tip pens.

1. Name

Please provide the name of the facility (as known to the public for which you are applying for this license.

Facility Name

2. Facility Contact Person:

Please provide the name and phone number of the contact person for this facility

First Name

Last Name

Contact Phone

Contact Fax Number

3. Facility Mailing Information

It is your responsibility to notify the board of all address changes.

1st Line Address (Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Phone

Extension

Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

4. Facility Location Address

It is your responsibility to notify the board of all address changes.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Extension

Business Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

5. Type of Ownership

- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Partner
- ☐ Sole Proprietorship
- ☐ Limited Partnership
- ☐ Partnership
- ☐ Governmental Entity
- ☐ Other (Describe):

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.

Postal Code, 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)

Federal Employer Identification Number (FEIN)

"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 Divison of Taxation to verify that no taxes are owed to the State."

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. 1 Year must be in long term care.

First Name

Last Name

Contact Phone

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 Seal

_____ _____

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 texbooks/workbooks to be utilized by students enrolled in the program.
- ☐ A systematic plan for on-going evaluation of the curiculum;
- ☐ 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 ina 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.**