KANSAS DEPARTMENT OF AGING AND DISABILITY SERVICES
INSTRUCTOR APPLICATION FOR CNA, CMA AND HHA TRAINING COURSES

Mark type of course. □ Nurse Aide Curriculum □ Home Health Aide Curriculum □ Medication Aide Curriculum

KDHE OFFICE USE ONLY

Instructor ID #______________________	CNA	Approval Date____-____-____	Disapproval Date_____-_____-
Reviewer Signature ______________________________	CMA	Approval Date____-____-____	Disapproval Date_____-_____-
	HHA	Approval Date____-____-____	Disapproval Date_____-_____-

Following approval, please use the six-digit Instructor ID# which has been assigned by the department. Include the assigned Instructor ID# on all future correspondence with the department.

Type or print in all information that is requested. This application should be received by this department at least three weeks prior to offering an initial nurse aide, home health aide or medication aide update training course.

APPLICANT, PLEASE NOTE: The attached CNA-CMA-HHA Instructor Employment Verification forms **must** be completed by current/former employer(s) for **each reference** listed on the application. All employment verifications must be received by Health Occupations Credentialing before the application can be processed.

Applicant Information

Name____
First MI Last Other

Social Security Number___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth ______/_____/_______

Mailing Address____
Street City State Zip

Home Address ____
Street City State Zip

Phone # (home) ( )____________________ (work) ( )____________________

E-mail address ____

Kansas Licensure # (LPN/RN) __ __/__ __ __ __ __ __/__ __ __ Expiration Date ___-__-___
mm yr.

Instructor Qualifications:

NURSE AIDE INSTRUCTOR:
According to state and federal standards, each course instructor must be a registered nurse with a current Kansas license and have a minimum of **two years' full time** licensed nursing experience. At least 1,750 hours must be as a licensed nurse in a setting which demonstrates long-term geriatric nursing care, such as an adult care home or a distinct-part long term care unit or a state institution for the mentally retarded. Additionally, all nurse aide instructors must have experience supervising nurse aides **or** teaching adults **or** completed a course in teaching adults **or** a professional continuing education offering on supervision or adult education.

HOME HEALTH AIDE INSTRUCTOR:
According to state and federal standards, each instructor of a home health aide course must be a registered nurse with a current Kansas license and have direct work experience in the provision of home health care. In order to qualify as an approved instructor, the state requires that the candidate be a registered nurse with a **minimum of two years full time=** licensed nursing experience. At least 1,750 hours must be as a licensed nurse in home health care services.

To document alternative home health care setting: AAlternative Practice Setting Experience@ form is available upon request.

MEDICATION AIDE INSTRUCTOR:
Each instructor must be a registered nurse with a current Kansas license and have **two years full-time** clinical experience as a registered nurse.

Employment Information (<u>Licensed Nursing Experience</u>)
Please provide only the employment information on the following pages that directly demonstrates that you meet the instructor qualifications previously described. If additional space is needed, please follow the same format as this form. A resume may not be substituted for the information requested in this section.

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _________________ mm / dd / yr. To: _________________ mm / dd / yr.		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides __________
Type of Work____________________________ Dispensed Medication ________
Employment Verification Attached ________

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _________________ mm / dd / yr. To: _________________ mm / dd / yr.		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides _________
Type of Work____________________________ Dispensed Medication ________
Employment Verification Attached ________

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _________________ mm / dd / yr. To: _________________ mm / dd / yr.		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they did. Number of aides __________
Type of Work____________________________ Dispensed Medication __________
Employment Verification Attached ________

Adult Education Training Course

Training School Name	TRAINING COURSE IN ADULT EDUCATION OR A PROFESSIONAL CONTINUING EDUCATION COURSE ON SUPERVISION OR ADULT EDUCATION MAY BE DOCUMENTED BY SUBMISSION OF POST-SECONDARY TRANSCRIPT OR CERTIFICATE OF COMPLETION.
School Mailing Address	
Dates of Attendance From: ________________ To: ___________________ mm/dd/yr. mm/dd/yr.	

NOTE: Course instructors and sponsors are responsible for being knowledgeable of and adhering to all pertinent statutes, regulations, policies or administrative guidelines in making application for course approval including but not limited to Kansas Statutes Annotated 39-926, Kansas Administrative Regulations 28-39-165 through 170, the Kansas 90-Hour Nurse Aide, Home Health Aide, or Medication Aide Curriculum Guidelines.

Signature of Applicant: I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments. I do hereby acknowledge that it is my responsibility to obtain employment verification from current/previous employer(s) for each reference listed on the application. I am fully aware that failure to provide this information to Health Occupations Credentialing will delay the processing of this application.

Signature ___________________________________ Date___________

Please complete all the employment information that demonstrates that you meet the instructor qualifications and attach the employment verification forms which have been completed by each employer and return to:

Health Occupations Credentialing
Kansas Department of Health and Environment
612 S Kansas Ave
Topeka, KS 66603

Phone number: (785) 296-1250
e-mail address: betty.domer@kdads.ks.gov

KDHE OFFICE USE ONLY

CNA Instructor # _____________________ Approval Date____-____-____ Disapproval Date_____-_____-

CMA Instructor # _____________________ Approval Date____-____-____ Disapproval Date_____-_____-

HHA Instructor # _____________________ Approval Date____-____-____ Disapproval Date_____-_____-

Reviewer Signature____________________________________

Comments:

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HEALTH OCCUPATIONS CREDENTIALING
612 S Kansas Ave
Topeka, KS 66603

CNA-CMA-HHA INSTRUCTOR EMPLOYMENT VERIFICATION

APPLICANT: COMPLETE THIS SECTION
(Photocopy as needed and send to each employer listed on your application.)

Social Security Number _______-______-___________ RN License Number _____/_____________/_____

Name ____
(Last) (First) (M.I.)

Other Names Used ____

Address ____
(Street) (City/State) (Zip)

Phone Number (Home) _______________________________ (Work) ____________________________

By my signature, I authorize the release of employment verification from the facility named below to the Kansas Department of Health and Environment.

Signature ____ Date ______________________________

EMPLOYER: COMPLETE THIS SECTION

Name of Facility ____ Telephone number (____)_____________

Address ____

Type of facility: Adult Care Home _____ Hospital_____ Home Health Agency ______ Other (Explain) _______________

Comments:

I certify that the individual named above is/was employed by me as an LPN or RN (Circle one)

from ______________________________ to _______________________________.

This individual was employed as a licensed nurse as follows **(number of hours per week must be included)**:

In an adult care home or distinct-part long term care unit from ____________ to _______________ Hours per week: _______

In home health care services from _________________ to _________________ Hours per week: _______

Other licensed nursing experience from ________________ to __________________ Hours per week: _______

Experience in administering medication _____Yes _____No

Please explain if other licensure setting ____

Signature ____ Date___________________________________
Title ____