

Employment Information (Licensed Nursing Experience)

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: _____ To: _____ mm / dd / yr 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: _____ To: _____ mm / dd / yr 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: _____ To: _____ mm / dd / yr 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/yy mm/dd/yy	

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:

