

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING

SECTION A1 - Sponsor Evaluation Form

This form is to be completed by the sponsor of the course within 10 days of course completion. It will be returned with the instructor's and facility representative's evaluation forms (A2 & A3) and a summary of the student evaluations to Health Occupations Credentialing, 612 S Kansas Ave., Topeka, KS 66603.

Course # _____

1. Name of Facility: _____

2. Name of Sponsor: _____

3. Course Dates: ____/____/____ to ____/____/____

4. Number of students enrolled in the class: _____

5. Number of students who successfully completed the course: _____

Circle the appropriate answer with "5" being strongly agree through "1" being strongly disagree.

6. Program Requirements Met

	Strongly Agree		Strongly Disagree		
a. The Kansas 90-Hour Nurse Aide Curriculum (including the Skills Competency Checklist) was used for this course.	5	4	3	2	1
b. The instructor supervised and evaluated the student during the course. No delegation of instruction occurred.	5	4	3	2	1
c. KDHE was notified of any program changes, i.e., instructor, time frames, content.	5	4	3	2	1
d. Opportunity was available for those involved in the training to comment on the delivery of the training.	5	4	3	2	1

7. A brief summary of the student evaluations follows:

8. Was this course's instructor allowed to be an employee of the facility? YES NO
If yes, please comment on this situation, i.e. did this present any problems or concerns, did this result in any positive situations?

9. Quality Assurance Requirements Met

a. Communication was open among the sponsor, instructor,
and facility representative. 5 4 3 2 1

b. Problems were resolved to the satisfaction of all parties. 5 4 3 2 1

10. Describe any concerns that were communicated about staff or students not meeting clinical standards and how the concerns were resolved.

11. Results of Training

a. Positive changes have occurred as a result of the training. 5 4 3 2 1

12. Describe any positive changes that have occurred because training was allowed in this facility.

13. Additional Comments:

14. _____ /_____/_____
Sponsor Coordinator Name Signature of Coordinator Date

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SECTION A2 - Instructor Evaluation Form

This form is to be completed by the instructor of the course and returned to the sponsor within 5 days of the completion of the course.

Course # _____

1. Name of Facility: _____

2. Name of Sponsor: _____

3. Course Dates: ____/____/____ to ____/____/____

4. Number of students enrolled in the class: _____

5. Number of students who successfully completed the course: _____

Circle the appropriate answer with "5" being strongly agree through "1" being strongly disagree.

6. Adequate Environment Strongly Agree Strongly Disagree

a. The classroom was adequate, i.e., comfortable, well-lighted, clean, etc. 5 4 3 2 1

b. Equipment was available for use when needed. 5 4 3 2 1

c. Good interaction occurred among students, instructor and facility staff. 5 4 3 2 1

7. Program Requirements Met

a. The Kansas 90-Hour Nurse Aide Curriculum (including the Skills Competency Checklist) was used for this course. 5 4 3 2 1

B. KDADS was notified of any program changes, i.e., instructor, time frames, content. 5 4 3 2 1

8. Quality Assurance Requirements Met

a. Communication was open among the sponsor, instructor, and facility representative. 5 4 3 2 1

b. Problems were resolved to the satisfaction of all parties. 5 4 3 2 1

9. Describe any concerns that were communicated about staff or students not meeting clinical standards and how the concerns were resolved.

10. Results of Training

- a. Positive changes have occurred as a result of the training. 5 4 3 2 1
- b. The course led to improvements in facility practice. 5 4 3 2 1
- c. Facility staff are more aware of clinical standards. 5 4 3 2 1

11. Describe any positive changes that have occurred because training was allowed in this facility.

12. When was information given to you on how to register complaints with the State Agency?

13. When was information given to the students on how to register complaints with the State Agency?

14. Additional Comments:

15. _____ / ____ / ____
Instructor Name Signature of Instructor Date

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SECTION A3 - Facility Evaluation Form

This form is to be completed by the facility representative for the course and returned to the sponsor within 5 days of the completion of the course.

Course # _____

1. Name of Facility: _____

2. Name of Sponsor: _____

3. Course Dates: ____/____/____ to ____/____/____

Circle the appropriate answer with "5" being strongly agree through "1" being strongly disagree.

4. Adequate Environment Strongly Agree Strongly Disagree

a. The classroom was adequate, i.e., comfortable, well-lighted, clean, etc. 5 4 3 2 1

b. Equipment was available for use when needed. 5 4 3 2 1

c. Good interaction occurred among students, instructor and facility staff. 5 4 3 2 1

5. The facility remained in compliance throughout the course. YES NO

6. Quality Assurance Requirements Met

a. Communication was open among the sponsor, instructor, and facility representative. 5 4 3 2 1

b. Problems were resolved to the satisfaction of all parties. 5 4 3 2 1

7. Describe any concerns that were communicated about staff or students not meeting clinical standards and how the concerns were resolved.

8. Results of Training

a. Positive changes have occurred as a result of the training. 5 4 3 2 1

b. The course led to improvements in facility practice. 5 4 3 2 1

c. Facility staff are more aware of clinical standards. 5 4 3 2 1

9. Describe any positive changes that have occurred because training was allowed in this facility.

10. Additional Comments:

11. _____ / _____ / _____
Facility Representative Name Signature of Facility Representative Date