KANSAS DEPARTMENT OF AGING AND DISABILITY SERVICES

INSTRUCTOR APPLICATION FOR CNA, CMA AND HHA TRAINING COURSES

Mark type of course: __ Nurse Aide __ Home Health Aide __ Medication Aide

Instructor Qualifications:

NURSE AIDE:
1-Hold a current **Kansas Registered Nurse license**
2-Minimum of **two years full-time licensed nursing experience** (LPN or RN) including one of the following:
- A. At least 1,750 hours of that experience must be as a licensed nurse in a setting which demonstrates long-term nursing care, such as an adult care home, long term care unit of a hospital or a state institution for the mentally retarded **or**
- B. complete at least 7 hours professional continuing education in "Person Centered Care for the Adult Care Home".

3-Meet **at least one of the following** requirements:
- A. Experience supervising nurse aides **or**
- B. Experience teaching adults **or**
- C. Complete a course in teaching adults **or**
- D. Complete a professional continuing education offering on supervision or adult education.

MEDICATION AIDE:
1-Hold a current **Kansas Registered Nurse license *for a minimum of two years***
2-Minimum of **two years full-time clinical experience** as a registered nurse (not LPN).

HOME HEALTH AIDE:
1-Hold a current **Kansas Registered Nurse license**
2-Minimum of **two years full-time licensed nursing experience** (LPN or RN) including at least 1,750 hours as a licensed nurse in home health care services.

Complete and Submit Application assuring it is received by KDADS/HOC at least three weeks prior to offering an initial Nurse Aide, Home Health Aide or Medication Aide training course.

APPLICANT INFORMATION:

Name _____
First MI Last Other

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Date of Birth _____/_____/_____

Mailing Address _____
Street City State Zip

Phone # (home) ( )_____ (work) ( )_____

E-mail address _____

Kansas Licensure # (LPN/RN) ___ ___/___ ___ ___ ___ ___ ___/___ ___ ___ Expiration Date ___-___-___

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.

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: _________________ mm / dd / yr To: _________________ mm / dd / yr		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they performed:
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 performed:
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 performed:
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 a post-secondary transcript or certificate of completion.
School Mailing Address	
Dates of Attendance From: _____ To: _____ mm/dd/yy mm/dd/yy	

APPLICANT SIGNATURE: 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 employment information which demonstrates meeting instructor qualifications and attach the employment verification forms which have been completed by each employer then return to:

Health Occupations Credentialing
Kansas Department for Aging and Disability Services
612 S Kansas Ave
Topeka, KS 66603

KDADS OFFICE USE ONLY

Instructor ID #_____	CNA	Approval Date_____	Disapproval Date_____
Reviewer Signature _____	CMA	Approval Date_____	Disapproval Date_____
	HHA	Approval Date_____	Disapproval Date_____

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 for Aging and Disability Services.

Signature _____ Date _____

EMPLOYER: COMPLETE THIS SECTION (not to be completed by applicant)

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 dates:_____ to _____ Hours per week: _____

In Home Health Care services from dates: _____ to _____ Hours per week: _____

Other licensed nursing experience from dates: _____ to _____ Hours per week: _____

Experience in administering medication _____Yes _____No

Please explain if other licensure setting _____

Signature _____ Date_____

Title _____