

KANSAS DEPARTMENT OF AGING AND DISABILITY SERVICES  
**CNA Course Supervisor Application**

**Course Supervisor Overview:** All approved CNA course sponsors must designate at least one Course Supervisor for their CNA training program. The Course Supervisor if not the primary instructor, shall provide general supervision of the nurse aide training course. General supervision means a Course Supervisor's provision of the necessary guidance and maintenance of ultimate responsibility for a nurse aide training course in accordance with the standards established by the department.

**Course Supervisor Qualifications:**

- 1- Hold a current Kansas Registered Nurse license or current RN unencumbered 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 those with mental and physical disabilities.
- 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.

**Course Supervisor Roles and Responsibilities:**

- Ensure submission of the application for the Approval of Training Course or provide the Course Sponsor with the required information for their submission of the application
- Acts as liaison with the department related to the program's continuing compliance with the required elements of these regulations
- Implement and maintain a nurse aide training program that complies with the department regulations
- Ensure submission of reports and program data upon requests of the department
- Coordinate the classroom and clinical site to ensure the environment is conducive to teaching and learning; and will provide the opportunity for students to perform the skills taught in the curriculum
- Ensure all instructors and persons conducting the skills competency checklist meet the required qualifications
- Provide or arrange for the orientation of the instructor to their role and responsibilities
- Supervise and verify instructors that do not have the long term care experience receives the hours of professional continuing education on person-centered care required yearly
- Evaluate instructors ongoing and formally on an annual basis
- Ensure an instructor is available for direct supervision scheduled clinical instruction
- Coordinate direct supervision of students in the clinical setting
- Evaluate each student and ensure they complete the part I checklist for instructors that do not have the long term care experience prior to the students starting clinical
- Assess students' reaction to course content, instructional effectiveness, and other aspects of the learning experience
- Verify the nursing home or long-term care unit of the hospital in which the training program is offered or utilized for the clinical experience is licensed by the Kansas Department of Aging and Disability Services in substantial compliance with all standards for licensure and has not been found within the preceding two years by the state survey and certification agency, using the currently applicable Center for Medicare and Medicaid Services regulations, categorized as providing substandard quality of care
- Approve qualified CNA instructors to teach the nurse aide training course and maintains documentation of instructor qualifications for HOC reviews.

**Instructor Qualifications:**

- 1- Hold a current Kansas License Practical Nurse (LPN)/Registered Nurse (RN) license **or** current LPN/RN unencumbered license and shall be in good standings
- 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 those with mental and physical disabilities.  
or  
**\* b. Complete at least 7 hours professional continuing education in "Person Centered Care for the Adult Care Home". (This must be completed on a annual basis)**
- 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

\*NATCEP Checklist-Part 1, an RN with 1750hr of LTC experience shall be required to evaluate and sign the completed checklist.

Approved Course Sponsor Name: \_\_\_\_\_ Course Sponsor Facility ID# \_\_\_\_\_

CNA Course Sponsor Roles and Responsibilities:

- Ensure a completed Course Supervisor application is submitted 3 weeks before initial CNA course.
- Ensure at least one approved course supervisor has been designated and KDADS approved in order to be eligible to conduct CNA courses.
- Ensure each course supervisor, instructor, and supplemental instructor shall meet the requirements of the designated positions as specified in subsections
- Ensure that a completed course approval application is submitted to the department at least three weeks before offering any initial or subsequent nurse aide training course.
- Request any changes in course supervisor, course location, or course schedule for prior approval.
- Ensure all course objectives shall be accomplished.
- Ensure that the course is prepared and administered in accordance with the "Kansas certified nurse aide curriculum guidelines (90 hours)" and the "Kansas certified nurse aide course (90 hour) instruction manual,"
- The provision of direct care to residents by a nurse aide trainee II during clinical instruction shall be under the direct supervision of the instructor and shall be limited to clinical experiences that are only for the purpose of learning nursing skills.
- Ensure during the clinical instruction, the instructor shall perform no duties other than the provision of direct supervision to the nurse aide trainees.
- Each nurse aide trainee in the 90-hour nurse aide course shall demonstrate competency in all skills identified on the part I nurse aide training and competency evaluation program task checklist to an RN, as evidence of successful completion of the training course.
- Ensure that the RN shall be licensed in the state of Kansas or with current unencumbered RN license with no pending or current disciplinary action against that person's license and shall have at least one year of licensed nurse experience in providing care for the elderly or chronically ill in a long-term care setting. This RN shall date and sign the checklist verifying the nurse aide trainee's skills competency.

By signing below you are agreeing that as the authorizing person for the course sponsor listed above that all roles and responsibilities as a Course Sponsor will be met. The applicant below meets all qualifications and aware of their role and responsibilities if approved as a Course Supervisor.

\_\_\_\_\_ EMAIL \_\_\_\_\_  
Signature Date

APPLICANT INFORMATION:

Name: \_\_\_\_\_  
First MI Last Other

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone # (cell) ( ) \_\_\_\_\_ (work) ( ) \_\_\_\_\_

E-mail address \_\_\_\_\_

Kansas Licensure # (LPN/RN) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Expiration Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_

If already approved KS CNA Instructor # \_\_\_\_\_ \*

**PLEASE NOTE:** The attached CNA Course Supervisor 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.

**\*If previously approved as a KS CNA Instructor whom possessed 1750HRS of LTC experience, please disregard the Employment information and Employment Verification form found below.**

**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 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: _____ To: _____ mm / dd / yr 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: _____ To: _____ mm / dd / yr 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.

I also recognized if approved as a Course Supervisor, that at any time my approval to serve as a course supervisor can be withdrawn, for the following reasons.

- 1) Any misrepresentation.
- 2) Should I fail to carry out my responsibilities, as a Course Supervisor
- 3) Should I fail to adhere to Federal and State educational protocols or regulations

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 by one of the three following methods mail, email or fax.

Health Occupations Credentialing  
 Kansas Department for Aging and Disability Services  
 503 S Kansas Ave  
 Topeka, KS 66603  
 Email: mike.hays@ks.gov  
 Fax 785-296-3075

<i>KDADS OFFICE USE ONLY</i>		
Course Supervisor ID# _____		
Reviewer Signature _____	Approval Date _____	Disapproval Date _____

HEALTH OCCUPATIONS CREDENTIALING  
503 S Kansas Ave, Topeka, KS 66603

**CNA 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 \_\_\_\_\_