NURSE AIDE TRAINING PROGRAM
APPLICATION FOR APPROVAL
HEALTH AND HUMAN SERVICES
HEALTH FACILITIES
04-2026

Legal name of facility offering the nurse aide training program

_____

Street Address _____

City _____ State Zip _____

Name of administrator of facility _____

Name of person completing this form _____

Title _____

Email Address _____

Street Address _____

City _____ State Zip _____

Telephone number _____

Name and address of chairman of the board, if applicable

Name_____

Street Address _____

City _____ State _____ Zip

Nurse Aide Training Program

Planned Implementation Date _____

Frequency and Sequence of program offerings_____

Planned Number of Students Per Class _____

Name and Title of the Registered Nurse Program Coordinator

Name _____

Title _____

North Dakota License Number _____

Describe the Program Coordinator's years of nursing experience and the number of years of experience in the care of the elderly and chronically ill in relation to the following.

Name and location of facility, years of employment, full or part time employment, and responsibilities.

Will the program coordinator act as the instructor for the nurse aide training program?

☐ Yes ☐ No

If the answer to number 12 is no, complete the following information for each instructor. Make copies as needed for each additional instructor.

Instructors, please attach additional pages if necessary.
Provide the following information relating to the instructors.

Name and title of instructor(s) of nurse aide training program, North Dakota license number, if applicable, Years of employment in profession, including name and location of employer, years of employment (indicate full or part-time) and responsibilities

Supplemental Instructors, please attach additional pages if necessary.

Identify the name, profession and work experience of each health professional utilized to assist in the instruction of the nurse aide course.

Physical Plant
Describe the classroom space available for instruction. Include location, seating capacity, writing space, lighting, and temperature control.

Describe the clinical laboratory space available for instruction, including location, lighting, and temperature control.

List the teaching equipment available for simulation of resident care and the audiovisual equipment available for instruction.

Clinical Facilities
List the facility where the students will receive supervised clinical experience.

Give the maximum number of students for each facility and the instructor/student ratio for clinical experience

Submit proof of Medicare/Medicaid participation, nursing facilities only.

Course Content

Submit a copy of the nurse aide training program course curriculum. Include an outline showing

- Subjects taught
- Length of time spent on each subject
- Length of time spent in supervised practical training
- When the student will have the first direct contact with residents

Length of the course in hours_____
Number of hours of classroom instruction _____
Number of hours of supervised practical training _____
Total number of hours of clinical instruction, if applicable _____

Describe how students will be evaluated during the course, to determine if they are competent in each procedure.

Describe how you will determine which skills the student has been trained for and determined proficiency by the instructor. Attach the form you are utilizing to document this.

Describe the plans for the course evaluation

Provide information regarding how the program meets the requirement which prohibits charging of nurse aides who are employed or have an offer of employment by a nursing facility.

Competency Evaluation Program

Which state-approved competency evaluation program will your nurse aide training program utilize for testing of nurse aides.

☐ HEADMASTER

If you use Headmaster, please complete the Nurse Aide Copetency Evaluation, proctored at facility section.

I certify that the information given in this report is true and accurate.

Signature of person completing form _____

Date _____

Nurse Aide Competency Evaluation, proctored at facility

How do you advise the individual taking the competency evaluation in advance that a record of successful completion will be included in the state's nurse aide registry?

What provisions are available for oral examinations?

Name of program personnel who will proctor the written or oral portion of the competency evaluation

Name of Proctor _____

License number, if applicable _____

Name of registered nurse who will proctor the skills demonstration part of the competency evaluation

License number, if applicable _____

Experience in providing care for the elderly or the chronically ill of any age.

Attach a copy of the letter or certificate from nurse aide test vendor confirming the registered nurse identified above is approved as a proctor.

How does the competency evaluation program inform the individual who does not satisfactorily complete the evaluation of the areas which she/he did not pass and that she/he has up to three opportunities to take the evaluation.

Please provide information regarding how the program meets the requirements which prohibit charging fees to nurse aides who are employed by or have an offer of employment by a nursing facility.

Signature of person completing form _____

Date _____