KANSAS DEPARTMENT OF AGING AND DISABILITY SERVICES

INSTRUCTOR APPLICATION FOR CNA TRAINING COURSES

(Course Supervisor Use Only)

CNA Instructor Qualifications:

1-**Hold a current Kansas Practical Nurse License (LPN) or Kansas Registered Nurse (RN) license or current LPN/RN unencumbered license.** License must not have any pending or current disciplinary actions.

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" in the last year. (This must be completed on 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 1750HRS of LTC experience shall be required to evaluate and sign the completed checklist.

Course Supervisor Use only:

#1 and #2 are required, Either #2A or #2B will need to be checked and One of the Subcategory for #3 will need to be checked

Check the box next to the number if criteria is met:

#1 ☐ #2 ☐ #2A ☐ #2B ☐ #3A ☐ #3B ☐ #3C ☐ #3D ☐

Complete and Submit Application assuring it is received by the designated course supervisor.

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 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 the designated course supervisor 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: _____ 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.

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 the designated course supervisor.

COURSE SUPERVISOR USE ONLY

Course Supervisor Name _____ Approval Date_____ Disapproval Date _____

Course Supervisor Signature _____

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 _____