

# **APPLICATION**

**Developmentally Disabled Care  
Nurse Aide Training**

**AND**

**Competency Evaluation Programs**

**Oklahoma State Department of Health  
Protective Health Services  
Nurse Aide Registry  
1000 NE 10th  
Oklahoma City, OK 73117-1299**

# General Information

The Oklahoma State Department of Health (OSDH) is responsible for implementing rules and approving programs that meet Federal and/or State requirements for a nurse aide training and competency evaluation program.

The application and necessary forms are enclosed. Please retain a copy of the original application and forms in your files and prepare additional copies for use as needed.

The completed application and application fee of fifty dollars (\$50.00) must be returned to:

Oklahoma State Department of Health  
Protective Health Services  
Nurse Aide Registry 1000 NE 10th  
Oklahoma City, OK 73117-1299

An approved program shall notify the OSDH when there are substantive changes made to the program.

Please call the Nurse Aide Registry staff at (405) 271-4085 or 1-800-695-2157 if you have questions about this information. We appreciate your participation and look forward to working with you.

Sincerely,

Lisa McAlister, BSN, RN  
Director, Nurse Aide Registry  
Protective Health Services

# Application

The application for a State approved nurse aide training and competency evaluation program determines if the program meets the Federal and/or State requirements for such programs. All information shall be a public record. The Department shall notify an applicant within ninety (90) days of its decision.

## Instructions:

1. Read the instructions carefully and complete the appropriate forms as indicated. Additional pages may be inserted if the allotted space is not sufficient.
2. \_\_\_\_ Label the appropriate forms for the specific section; i.e., Section #  
\_\_\_\_\_ Page # .
3. Indicate NA (not applicable) on forms as necessary.
4. Submit the complete Application and application fee of fifty dollars (\$50.00) to:

Oklahoma State Department of Health  
Protective Health Services-0702 Nurse  
Aide Registry 1000 NE 10th  
Oklahoma City, OK 73117-1299

<b>Entity Name:</b> _____
<b>Mailing Address:</b> _____
_____
<b>City</b> <b>State</b> <b>Zip</b>
<b>Contact Person:</b> _____
<b>Telephone:</b> (      ) _____
<b>Area Code/Telephone Number</b>

**Program Category:**

Please check one:

- Facility Program
- Accredited Higher Education Institution
- State Vocational and Technical Education School
- Private Vocational School

A private Vocational School shall submit a copy of the license issued by the Oklahoma Board of Private Vocational Schools. Attachment #

Other

**Program Eligibility:**

The Department shall not approve, or shall withdraw approval of an employer based program when the employer has been assessed the following penalties or actions by the Department:

1. License suspended or revoked or had a conditional license issued.
2. An administrative money penalty of five thousand dollars (\$5,000.00) or more for deficiencies cited under state licensure.
3. Closed or had its clients transferred pursuant to the OSDH's action.
4. Repeated enforcement actions based on the OSDH's authority.

I, \_\_\_\_\_ Name of  
Administrative Official

1. Agree that the OSDH may not approve or shall withdraw approval for a nurse aide training and competency evaluation program on finding that any of the reasons for such action occur.
2. Verify that the facility is eligible to provide a nurse aide training and competency

evaluation program.

Signature of Administrative Official

  /  /    
Date

## **Section I. Records and Evaluation**

A nurse aide training and competency evaluation program shall use a Trainee Performance Record approved by the OSDH that indicates the major duties and skills taught.

The Trainee Performance Record shall include, but not be limited to:

1. A listing of the duties and skills expected to be learned in the program.
2. A record of when the trainee performs the duties and skills and the determination of satisfactory or unsatisfactory performance. The name of the instructor or evaluator supervising the performance.
- 3.

**Submit a copy of the Trainee Performance Record form. Attachment #**

A program shall retain the following records for at least three (3) years:

1. Application for the nurse aide training and competency evaluation program.
2. Trainee performance record and individual training records.

**Describe the method used for retaining the required records safely for at least three (3) years. Attachment #**

3. Trainee's performance on the competency evaluation program, i.e., successful or unsuccessful.

### **Training Program Information:**

An approved program shall provide current written information to applicants about: 1.

1. Policies for admission and satisfactory completion of the program.
2. Purpose and objectives of the program.
3. Trainee rights and responsibilities.
4. Successful completion of a nurse aide training and competency evaluation program results in the individual being listed in the OSDH's nurse aide registry.
5. State law requiring employers to secure an Oklahoma State Bureau of Investigation criminal arrest report.

**Provide a copy of the written information, (items 1 though 5 listed above), that is provided to applicants. Attachment # \_\_\_\_\_**

## **Section II. Charges**

**If there is to be a charge, submit an itemized list of charges made to trainees.  
Attachment # \_\_\_\_\_**

## **Section III. Trainees**

**The trainee shall be appropriately identified as a trainee whenever the individual is performing the required clinical skills training.**

**Describe the method used to identify trainees.**

## **Section IV. Clinical Facilities**

**An educational based program shall submit a list of clinical facilities and a copy of letters of agreement for use of the clinical facilities signed by the nursing clinical site administrator and the program administrative official. Attachment #**

## **Section V. Instructors**

**General Information: You must notify the nurse aide registry for approval any time a change occurs in the following areas: course location, curriculum, or program instructors.**

**Instructors for the training of developmentally disabled direct care aides shall be a licensed nurse or a qualified mental retardation professional (QMRP) who has at least one (1) year experience in the provision of services in a facility for the developmentally disabled.**

Other personnel from the health professions may supplement the instructor as required by the curriculum.

Complete the attached Instructor Qualification Record for each person serving as an instructor. Additional copies of the Instructor Qualification Record form can be made and attached.

### Instructor Qualification Record Training

Entity Name:

Training Entity Location

Street

City

Zip

I. Instructors: (Name)

Licensed Nurse \_\_\_\_\_ SS# \_\_\_\_\_  
Certificate No. Annual # \_\_\_\_\_ OR

QMRP

A. Experience:

1. Indicate number of years' experience in a developmentally disabled facility -- must be at least one (1) \_\_\_\_\_ .

II. Supplemental Instructor and area of expertise

Administrative Official, Co-Signature \_\_\_\_\_

## Section VI. Curriculum

For a training and competency evaluation program to be approved it shall include:

- a. At least seventy-five (75) hours of classroom and supervised practical training. An approved curriculum.
- b.

<p>1. Name of Curriculum: _____ (Must be a State approved curriculum)</p> <p>Total Classroom hours: Total supervised practical training hours: Total clinical hours:</p> <p>2. Submit a copy of your course outline. Attachment #</p>
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## Section VII. Environment

The nurse aide training and competency evaluation program shall provide an environment conducive to learning. This shall include at least the following: heating and cooling temperature controls; clean and safe conditions; adequate space to accommodate all trainees; adequate lighting; necessary functioning equipment; training materials including audiovisual equipment and freedom from distractions, traffic and other activities.

<p>1. Indicate the largest number of trainees the classroom can accommodate. 2.</p> <p>Location of classroom.</p>
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	Yes	No	Date	Comments
<b>Temperature Controls 71 - 81 degrees</b> Heating Cooling				
<b>Clean, Safe Conditions</b> Floor clean, uncluttered  Electrical outlets available and working  Wastebaskets  Clock Available  Environmental hazards (identify & list on separate page)				
<b>Space</b> Adequate number of chairs  Adequate number of desks  Adequate space for trainees, equipment and materials.				
<b>Lighting</b> Direct lighting Suitable for tasks to be performed  Indirect lighting Minimal glare				
<b>Equipment &amp; Training Materials</b> Overhead projector, if needed  Reference books and materials  Supplies				
<b>Clinical Skills Lab</b> Clinical skills lab provides space for equipment and trainees  Mannequin, if needed				

Basic skills supplies, i.e., bath basin, personal care items, blood pressure equipment, patient beds, among others

Handwashing facility easily accessible

**Section VIII. Competency Evaluation Program**

**Written Oral Evaluation:**

An approved program shall make the written or oral and skills examinations available to trainees and shall inform the trainee about the competency evaluation program that is available on successful completion of the training program.

**Describe where/how the written or oral test is made available to trainees.**

**Clinical Skills Evaluation:**

The clinical skills demonstration shall be:

- (1) performed in a setting comparable to the setting in which the individual will function as a nurse aide; and
- (2) administered and evaluated by a licensed nurse or qualified mentally retardation professional (QMRP).

**Indicate where the clinical skills demonstration part of the competency evaluation program will be administered.**

**Clinical Skills Observer:**

If clinical skills testing is going to be performed at your training site, complete the information below and attach a copy of the record certifying the observer has completed the clinical skills observer course. Attachment # \_\_\_\_\_

**Name** \_\_\_\_\_

**Licensure Nurse Certificate #** \_\_\_\_\_ **Annual #** \_\_\_\_\_

**OR**

**QMRP (check if applicable)** \_\_\_\_\_