Please read the application in its entirety

Each section must be addressed

Missing items will cause a delay in the approval/re-approval/relocation process

Applications submitted for Approval must be complete for consideration.

APPLICATION FOR APPROVAL
NURSE AIDE TRAINING AND COMPETENCY
EVALUATION PROGRAM

Please submit original application and retain a copy for your records. Do not fax. Make sure that the individual completing the application signs and dates the appropriate page. If the application is incomplete it will not be considered for approval.

Please complete all 7 pages of the application for approval/re-approval of the nurse aide training program (NATP). Attach all requested information as outlined on the application. Review the enclosed Federal and State Core Curriculum and Skills Checklist. The enclosed skills checklist is MANDATORY. Skills may be added to the checklist but not deleted. All skills must be listed on the lesson plan the day of demonstration and return demonstration. The information MUST be enclosed with the application and mailed to Alliant Health Solutions.

All State of Georgia approved NATPs are required a minimum of 85 hours. The hours are divided between Classroom/Lab/Clinical. A minimum of 24 hours is required clinical rotation. Clinical rotation must be in a nursing home. The minimum 85 hours must cover the required NATP Federal and State Core Curriculum (CFR, Title 42, 483.150-483.158) and state requirements for clinical rotation.

- **NO CERTIFIED NURSE AIDE CLASSES CAN START UNTIL THE APPROVAL IS GIVEN BY THE STATE CONTRACTOR.**
- **Funds cannot be accepted from potential nurse aide students until the approval letter from the State Contractor is received.**
- **Pending programs cannot advertise for Certified Nurse Aide courses until the approval letter from the State Contractor is received.**

Private NATPs are required to have an on-site visit to the classroom prior to approval. All equipment listed on the equipment form for classroom/lab should be present prior to the visit. Failure to have the required equipment will postpone the approval of the program. Any NATP is subject to unannounced on-site visit at the discretion of the Alliant Health Solutions.

Programs are allowed to submit an application 3 times in 1 year. If the initial application is incomplete, denied because of insufficient material and/or there are needed corrections, there are 2 remaining opportunities to re-submit the requested information. The program contact person will receive an e-mail and/or letter from the reviewer outlining missing components and/or the need to edit elements of the application. If the third application is denied there is a wait period of 1 year from the date of the review letter.

Applications for approval for a new program have a 90 day time frame for approval. Re-approvals are required every 2 years and have a 45 day time frame for re-approval

Effective July 1, 2007, the written/oral and skills competency exam will be administered by Pearson VUE Information regarding standardized testing can be viewed and/or downloaded from www.pearsonvue.com, Search Nurse Aide Registry link.

Alliant Health Solutions
Nurse Aide Training Program

Policy: Submission of Application
(Approval, Re-Approval & Relocation)

Please read carefully, sign and date at the bottom of the page.

In a minority of cases applications may not be approved or re-approved. In these instances the Alliant Health Solutions Nurse Aide Program Reviewers spend an extended amount of time providing one-to-one feedback with applicants giving advice on how and what to include in an application.

The Alliant Health Solutions allows up to three (3) submissions of an application either for approval or re-approval of a Nurse Aide Training and Competency Evaluation Program.

Once an application is denied for the third time, the applicant will be able to submit another application at one year from the date of the last submission and after attendance at another Train-the-Trainer Workshop.

I, the undersigned, attest that I have read the above policy and understand that I have three attempts to submit an application for approval or re-approval. I also understand that within one year from the time of my last application submittal I can again apply for approval or re-approval once I have attended a Train-the-Trainer Workshop.

_____ _____

SIGNATURE **DATE**

ALLIANT HEALTH SOLUTIONS
NURSE AIDE TRAINING PROGRAM

Program Coordinators:

By signing, you are acknowledging the fact that when a change to the nurse aide training program is made Alliant Health Solutions must be notified in writing of the change. This includes any subject from pages one (1) – seven (7) of the approval/re-approval packet application.

Information must be submitted within ten (10) business days of the change. All changes must be approved prior to implementation.

Send information to:

Alliant Health Solutions
Nurse Aide Training Program
P. O. Box 105753
Atlanta, GA 30348
www.mmis.georgia.gov

Failure to submit the information will result in disciplinary action and/or withdrawal of the nurse aide training program.

Signature: _____

Date: _____

Alliant Health Solutions
Nurse Aide Training Program (NATP) Application

(Please print or type)

Program Offering Information
(Complete a separate application for each training program location):

Legal Business Name of Organization/School/Agency/Nursing Facility

_____
List all Affiliated Business Names, including Doing Business As (DBA)
_____ _____
_____ _____
_____ _____

Business Address:

Street _____

City_____Zip Code_____

County_____

Phone ( ) _____ Fax ( ) _____

Program's E-mail Address
(required)_____

Program's Contact
Person_____
Name Title

Name of Administrator of facility (if applicable) _____

E-mail Address_____

Program: (circle one) APPROVAL RE-APPROVAL RELOCATION

Title, Author and Edition of textbook- Academic Platforms**:** American Health Care Association's (AHCA) *How To Be a Nurse Assistant*
(***All textbooks must be within 5 years of the copyright date. Do not mail the textbook with submitted paperwork)***

Title of nurse aide
course_____
_____

Classroom/lab/clinical hours must correspond with total number of hours documented on the lesson plans/hourly breakdown form.

Day class- Use whole numbers only
Classroom hours _____ Lab hours _____ Clinical hours_____

Evening Class- Use whole numbers only
Classroom hours_____ Lab hours_____ Clinical hours_____

Weekend class- Use whole numbers only
Classroom hours_____ Lab hours_____ Clinical hours_____

Each time frame requires lesson plans and an hourly breakdown form for each class.

A minimum of twenty-four (24) hours of clinical is required in a nursing home.

Location of Classroom/Lab Training Site: New programs and relocation sites must have an onsite visit. The location can be pending upon application submission prior to scheduled on-site visit. See Page 6 of this application for additional information.

_____

_____

Provide a description of the classroom/lab to include seating capacity, writing space and describe method of lighting/temperature control: **This section must be provided to the State Contractor once the training site is obtained by the applicant**

_____

_____

_____

_____

_____

_____

Location(s) of Clinical Training Site(s) - The signed clinical contract must be obtained and submitted with the Nurse Aide Training Application. All applications submitted without the clinical contract **will not** be reviewed until the signed clinical contract is submitted. Failure to submit the signed clinical contract will delay the 90 day process.

Agency	Address	Type of patient care unit

Faculty- For this location only.

Program Coordinator - **must be a RN with two (2) years of nursing experience and one (1) year employment in a nursing home as a Registered Nurse.**

Please review the enclosed Program Coordinator's Guide for position guidelines.

Name	Title	GA License Number

Primary Instructors (RN or LPN) - **Must have one (1) year of nursing experience For this location only:**

Name	Title	GA License Number

Recommended student/instructor ratio is 14:1 in classroom/lab and clinical setting. Recommended student/instructor ratio may change based on the state contractor's on-site visit. Additional students require an additional instructor.

Expert Supplemental speaker (attached additional pages if necessary)
List the name, profession and work experience of each healthcare professional utilized to **assist** in the instruction of the nurse aide course. Examples of supplemental instructors are as follows: CPR certified instructor, Alzheimer's guest speaker, guest speaker on Ombudsman duties, etc. Refer to the Federal Guidelines (42CFR483.152) for Nurse Aide Training Programs for a complete listing of supplemental instructors. Supplemental instructors are required to have one (1) year of experience in their field.

Name	Job Title	Work Experience
Name	Job Title	Work Experience
Name	Job Title	Work Experience

*** Pearson Vue Nurse Aide Evaluator must administer the written/oral and skills competency exam to candidates for all programs including candidates testing for re-certification. Information provided at www.Pearson VUE.com.

First time applicants must submit all items listed below.

Please note any changes to the program during the two (2) year time period between re-approval should be submitted for approval within ten (10) days. The change cannot be implemented until approval is granted.

Place preparer's initials in front of each item submitted and reviewed.

___Program coordinator/instructor (s) – copy of current GA nursing license.

___Program coordinator/instructor (s) – copy of the Train-the-Trainer certificate and resume if not on file.

___Criteria for passing the course

___ Classroom/clinical attendance policies with make-up policy. All nurse aide students must complete the number of hours the program was approved for in order for the student to receive a Certificate of Completion.

___Equipment list with lab equipment- **(Pending is acceptable prior to scheduled on-site visit).**

___Instructor evaluation form

___Student evaluation form with provision for progress notes

___Program Acknowledgement form:
The enclosed program evaluation form is to be given to the student upon the completion of the nurse aide training program. All programs must keep a program acknowledgement form in each student's file acknowledging receipt of program evaluation **(program must develop the program acknowledgement form)**. The student is responsible for mailing the form to Alliant Health Solutions.

___**Print and review** the Nurse Aide Training Program Manual **quarterly**- (keep on file in office) www.mmis.georgia.gov, click on the provider information tab, click on view full list under the Medicaid Manuals section. This manual is updated quarterly. **DO NOT SUBMIT A COPY WITH APPLICATION.**

___**Review** the enclosed copy of the training program completion certificate. All information on the enclosed certificate must be on the certificate issued to the candidate at the **completion** of the nurse aide training program course. The date documented on the completion certificate should be the date of the completion of the program.

THE PROGRAM MUST HAVE A VALID E-MAIL ADDRESS.

- **Certified Nurse Aide Courses cannot start without the approval letter from the State Contractor;**
- **Funds cannot be accepted from potential nurse aide students until the approval letter from the State Contractor is received;**
- **Pending programs cannot advertise for Certified Nurse Aide Courses until the approval letter from the State Contractor is received;**
- **Do not submit text books with submitted paperwork;**
- **State Contractor Reviewer allowed ninety (90) business days for review of new programs;**
- **State Contractor Reviewer allowed forty-five (45) business days for review of re-approvals/relocation; and**
- **The State Contractor will advise the new program when the submitted paperwork is approved and schedule an on-site visit.**

RE-APPROVALS ONLY

The following documents must be submitted: Place preparer's initials in front of each item submitted.

___Nurse Aide Training Program Application (Pages 1-7)
___Current updated signed Clinical contract(s) - clinical contracts without expiration dates will not be accepted
___Updated copies of current nursing licenses for all approved instructors
___Current business license
___Enclosed **Mandatory** skills checklist with page/rubric information - additional skills may be added to the skills checklist
___Updated Lesson plans/hourly breakdown form with additional changes listed on the enclosed Federal & State Core Curriculum

Relocation Only

___Cover letter with detailed information regarding relocation
___ Nurse Aide Training Program Application (Pages 1-3 & 7)
___Copy of business license
___ Fire code inspection report
___ Fire evacuation procedure
___Equipment List

The application may not include complete requirements for the Georgia Nurse Aide Training Program. The applicant **must** read the Nurse Aide Training Program Manual located at www.mmis.georgia.gov (click on Nurse Aide/Medication Aide tab) for all requirements.

I certify that all the information on all pages of the application form is true and complete. False information will delay and/or withdraw the Georgia Nurse Aide Training Program approval/re-approval from the State Contractor.

_____ _____

Preparer's Signature **Date**

Mailing address:

Alliant Health Solutions
Nurse Aide Training Program
P. O. Box 105753
Atlanta, GA 30348
www.mmis.georgia.gov

Alliant Health Solutions Use Only

☐ Approved

☐ Denied

By: _____ _____

Reviewer Date

Program# _____ **Program Type**_____

NURSE AIDE TRAINING PROGRAM

All supplies must be stocked in adequate supply at all times

SUPPLIES MUST BE ADEQUATE FOR THE NUMBER OF STUDENTS ATTENDING

ENVIRONMENTAL CLEANLINESS MANDATORY

Rationale for equipment - to recreate a resident's room in the nursing home & for proper skills training.	**DATE**	**COMMENT**
Table/desk/chairs (desk must be arranged 3ft apart)		
Whiteboard - large		
TV/DVD (projector-optional)		
Videos (optional)		
Reference Books		
Disposable gloves - varied sizes (small, medium, large)		
Hospital Bed with side rails- must raise to working height (telescoping side rails ***NOT*** allowed)		
Full Body Manikin (complete with interchangeable M/F parts that fit properly)		
Wall Clock with second hand in lab area near sink		
Call Light		
Overbed Table		
Bedside Table with drawers for equipment placement		
Wheelchair with footrest and brakes		
Geri chair (optional for private programs and schools)		
Lift (optional for private programs and schools)		
Restraints for slip knot		
Heel/Elbow Protectors- several		
Walker with wheels		
Quad Cane		
Gait Belt - several		
Ambulatory scale/height measuring device		
Non-electronic/non-digital standing or bathroom scale		
Waste basket with plastic liners		
Tongues blades for stool specimen – several boxes		
Measuring tape for the height of bedridden		
Graduated cylinder - CLEAR PLASTIC (2) **(No Beakers)**		
Bedpan (standard and fracture)		
Urinal - MALE		
Bedside Commode		
Speci Pan		
Chux - package		
Incontinent Briefs - package		
Specimen cups with small clear biohazard bags		
Foley Catheter with closed drainage system		
Alcohol Wipes – several boxes		
Sphygmomanometer – Manual (Regular, Large, Extra Large)		
Thermometer Covers - Disposable – several boxes		
Thermometer – Digital or Electronic - several		
Thermometer - mercury-free oral/rectal - several oral		

Page 2	DATE	COMMENT
Stethoscopes - several		
Teaching Stethoscope		
Hamper with red biohazard bag for gown disposal		
Isolation gowns – several packages		
Masks – several boxes		
Eye Protection - several		
Sharps Container – Puncture Resistant for razors		
Washcloths-2		
Towels-2		
Twin Blanket-2		
Twin Bedspread-2		
Pillowcases–2		
Flat twin sheet-4-can use for draw sheet or bottom sheet		
Fitted twin sheet-2		
Hospital Gown-2		
Orange Sticks/emery boards – several boxes		
Toothbrush (each student must have one)/toothpaste/floss for oral care demonstration		
Denture cup/Dentures/ Denture Brush **(Adult Size Dentures)**		
Toothettes – several boxes		
Disposable Razors/Shaving Cream - several razors		
Wash Basin		
Liquid Soap & Body Wash Soap (Several)		
Emesis Basin		
Hair Brush/Comb- several		
Water Pitcher **(bedside pitcher 34 oz)/**Cup/ Straws		
Food Tray/Clothing Protector/Plate/Silverware		
Anti-embolic stockings (4)		
Pillows for head of bed and alignment - Six (6)		
Post Mortem Kit		
Sink – H/C water (faucet must extend outward to allow for proper handwashing)		
Privacy curtain or Door		
Nurse Aide Training Manual onsite (most recent)		
File Cabinet with Lock		
Heated/cooled environment/Clean Carpet/No loose wires		
Supplies must be organized in drawers or containers, or on shelves.		
Room accommodation for how many students-class/lab		
SIGNATURE OF PREPARER:_____ **REQUIRED: CLASSROOM EQUIPMENT & SUPPLIES MUST BE CLEAN, ORGANIZED, AND IN GOOD WORKING CONDITION AT ALL TIMES FOR NATP APPROVAL**		

Optional – Private programs, technical colleges and high schools may use "optional" equipment in a nursing facility for training – student must have skill checked off prior to working with residents requiring this equipment.

Private programs, technical colleges and high schools - weights must be taught and demonstrated in the nursing home.

For hair brushing demonstration, have students demonstrate hair brushing on manikin only.

REQUIREMENTS
FOR
PROGRAM COORDINATOR & INSTRUCTORS

Approved Nurse Aide Training Programs must designate a Program Coordinator and Primary Instructor(s). Programs cannot commence training until these individuals are approved.

Program Coordinator (PC):

Registered Nurse (RN) with two (2) years of nursing experience. One (1) year of nursing experience as an RN must be in a long-term care facility (nursing home). Duties of a Program Coordinator include but are not limited to:

- Overseeing the program in its entirety
- All required documentation for the yearly on-site review
- Assisting instructor in resolving any issues with students
- Making occasional on-site visits to classroom/lab and clinical sites to ensure proper instruction is taking place and documenting progress related to those visits
- Assisting with compilation of material presented for the approval or re-approval prior to submitting to the Georgia Nurse Aide Training Program
- Attending the first clinical rotation with all first time instructors **without** nursing home experience.

Please review the NATP Manual and PC Guide for additional job description

The facility administrator/director must mail a letter requesting approval for the RN to serve as Program Coordinator for the Nurse Aide Training Program. Please include a copy of the current GA nursing license, an updated resume, and a copy of the Train-the-Trainer Workshop certificate. Requirements are as follows:

- Registered Nurse with current **active** Georgia License and in good standing with the GA Board of Nursing- License cannot have the following status codes- probation, suspended, expired, lapsed, inactive, pending, renewal pending, revoked or surrendered
- Two (2) years of nursing experience as an RN, at least one year of experience as an RN must be in a long term care facility (nursing home).
- Train-the-Trainer Workshop attendance certificate from Alliant Health Solutions
- The Director of Nursing may serve as Program Coordinator in a facility based program, but provision for coverage of duties must be assured

Instructors

The Program Coordinator must mail a letter requesting approval for the LPN or RN to serve as an instructor in the classroom and/or clinical portion of the Nurse Aide Training Program. Please include a copy of the current GA nursing license, an updated resume and a copy of the Train-the-Trainer Workshop certificate. Requirements are as follows:

- Registered Nurse or License Practical Nurse with current **active** Georgia License and in good standing with the GA Board of Nursing- License cannot have the following status codes- probation, suspended, expired, lapsed, inactive, pending, renewal pending, revoked or surrendered
- Minimum one year of nursing experience
- Train-the-Trainer Workshop attendance certificate from Alliant Health Solutions

PROGRAM COORDINATOR'S GUIDE

Program Name & Number_____ **Program Coordinator (PC) Name: Print**_____ **Signature**_____	**DATE**	**INITIALS**
FILES IN ORDER FOR ANNUAL AUDIT - ON-SITE REVIEW - PAGE 11 TRAIN THE TRAINER BOOKLET - DATE WHEN FILES CHECKED		
REVIEWED PROGRAM WITH INSTRUCTOR PRIOR TO TEACHING - MADE EXPECTATIONS KNOWN - DATE		
TEAM MEETINGS HELD TO EVALUATE HOW PROGRAM IS PROGRESSING - DATE & RESULTS OF EVALUATION - DOCUMENT PLAN TO IMPLEMENT CHANGES		
PROBLEMS WITH PROGRAM DOCUMENTED & PROBLEM SOLVING METHODS INITIATED		
REVIEWED INSTRUCTOR EVALUATIONS FOR C/O & IMPROVEMENTS NEEDED - RESULTS DOCUMENTED		
ISSUES NEEDING RESOLUTION - DOCUMENT ISSUES & PLANS FOR RESOLUTION		
INSTRUCTOR(S) ON PROBATION - LIST REASON		
LESSON PLANS BEING FOLLOWED - MONITOR MONTHLY AND DOCUMENT		
SKILL RUBRICS BEING FOLLOWED - MONITOR MONTHLY AND DOCUMENT		
MONITOR EACH INSTRUCTOR IN CLASSROOM, LAB & CLINICAL - DOCUMENT FINDINGS AND FOLLOW-UP DATE		
INSTRUCTOR IMPROVEMENT AND VISITS MADE TO OBSERVE IMPROVEMENT		
MONITOR NEW INSTRUCTOR(S) FOR COMPETENCY OF INSTRUCTION - DOCUMENT FINDINGS & FOLLOW-UP DATE		
PC ATTENDANCE REQUIRED WITH FIRST TIME LTC INSTRUCTORS DURING CLINICAL ROTATION (ADDITIONAL ATTENDANCE MAY BE REQUESTED)		
ORGANIZE WITH THE INSTRUCTORS THE RE-APPROVAL APPLICATION - DATE		
ASSIST IN CREATING LESSON PLANS BASED ON NURSING HOME EXPERIENCE		
PASSING RATE ON WRITEN/ORAL/SKILLS COMPETENCY EXAM - INVESTIGATED INDIVIDUAL PROBLEMS WITH FAILING THE EXAM WITH INSTRUCTOR - DOCUMENT		
REVIEW STUDENT PROBLEMS WITH INSTRUCTOR AND ASSIST IN PROBLEM SOLVING - DOCUMENT		
ALL REQUIRED LAB EQUIPMENT ALL LOCATIONS PRESENT - DATE ASSESSED - NAME OF LOCATION		
NOTIFIED WITHIN TEN (10) DAYS OF ANY CHANGES TO THE PROGRAM - DATE & DOCUMENT CHANGE		
NOTIFIED OF INSTRUCTOR ADDITION OR DELETION - DATE		
CANDIDATE HANDBOOK FROM PEARSON VUE REVIEWED WITH INSTRUCTORS & DATE		
WHEN LOW SCORES NOTED ON SKILLS COMPETENCY - OBSERVE STUDENT PERFORMANCE AND/OR REVIEW STUDENT RECORDS		
ASSISTED IN THE HIRING PROCESS OF INSTRUCTORS - SUBMITTED LETTER OF INTENT, COPY OF NURSING LICENSE, RESUME & COPY OF TTT CERTIFICATE TO		
ATTACH DOCUMENTATION IF APPLICABLE		

INSTRUCTOR ORIENTATION

Instructor printed name: _____

Date of hire: _____

Instructor status (select all that applies): **approved** **temporary approval** **first time instructor**

Proctor and instructor to initial and date each of the following: **Proctor**: program coordinator and/or experience instructor

Orientation to the classroom, lab and equipment placement: _____ Date: _____ Length of time: _____

Orientation to the lesson plans and skills rubrics: _____ Date: _____ Length of time: _____

Instructor observation of proctor teaching & skills check-off methodology: _____ Date: _____ Length of time: _____

PC observation during clinical rotation for first time instructor: _____ Date:_____ Length of time: _____

Proctor observation of instructor teaching methodology: _____ Date: _____ Length of time: _____

Proctor observation of skills check-off methodology: _____ Date: _____ Length of time: _____

State Guidelines for the Nurse Aide Training Program have been reviewed: _____ Date: _____

Proctor printed name: _____ Proctor signature: _____ Date: _____
Proctor printed name: _____ Proctor signature: _____ Date: _____

Instructor signature: _____ Date: _____

When the new instructor and proctor have signed off on each tasks listed above a copy must be remain in the program's file all times for auditing purposes. Methodology includes use of approved lesson plans, skill rubrics, skills checklist and communication skills.

Date _____

Name of Long-Term Care Facility _____

Long-Term Care Facility Employee Verification Signature_____

Name of Nurse Aide Training Program _____

Please make sure all instructors and students sign this form upon entering and leaving the facility.

Print Name of Student	**Signature of Student**	**Time of ARRIVAL**	**Time of DEPARTURE**

Print Name of Instructor	**Signature of Instructor**	**Time of Arrival**	**Time of Departure**

NURSE AIDE TRAINING PROGRAM EVALUATION

Please complete this evaluation after you have completed the Nurse Aide Training Program:

Return to: **ALLIANT HEALTH SOLUTIONS**
NURSE AIDE TRAINING PROGRAM
P. O. Box 105753
Atlanta, Georgia 30348

Name of Nurse Aide Training School/Facility_____
Student's Name: _____
Student's E-mail Address: _____
Student's Phone Number (Optional): _____

- How many hours per day did you attend class - did you feel that the amount of hours were adequate for your learning needs? Hours: _____ YES ☐ or NO ☐
- What time did the classroom hours begin and end? Begin _____ End _____
- How many hours did you attend clinical? Hours: _____
- Did the instructor portray a professional mannerism? YES ☐ or NO ☐
  Comments _____
- Was the instructor knowledgeable on nurse aide training? YES ☐ or NO ☐
  Comments _____
- Was the instructor on time for classes and clinical rotation? YES ☐ or NO ☐
  Comments _____
- What was the name of your primary nurse aide training instructor?
  _____
- Did you have the same instructor throughout the class? If not list each instructor. If not a RN/LPN, what was the instructor's title? YES ☐ or NO ☐
  Comments _____
- Are you comfortable taking care of residents of a long-term care facility based on the classroom/lab and clinical training you received? YES ☐ or NO ☐
  Comments _____
- Was time allotted for the skills to be checked off with 100% accuracy in the lab portion of your training prior to clinical rotation? YES ☐ or NO ☐
  Comments _____

.

- Was the clinical rotation long enough for you to feel comfortable in caring for residents of a long-term care facility? YES ☐ or NO ☐
  Comments _____

- Was the instructor with you at all times during your clinical rotation? YES ☐ or NO ☐
  Comments _____

- Was there time allowed for questions to be answered? YES ☐ or NO ☐

  Comments _____

- Do you feel you received a quality education? YES ☐ or NO ☐
  Comments _____

- Would you recommend this Nurse Aide Training Program to a friend?
  YES ☐ or NO ☐
  Comments _____

- Did you perform vital signs (temperature, pulse, respiration and blood pressure) in the classroom and during clinical rotation? YES ☐ or NO ☐
  Comments _____

- Do you feel confident performing vital signs accurately? YES ☐ or NO ☐
  Comments _____

- If necessary, can your identity be revealed to the program? YES ☐ or NO ☐
  Comments _____

Additional Comments are welcomed: _____

_____

_____

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_____

Please use another sheet of paper if additional space is needed.

Georgia Nurse Aide Training Program Completion Certificate

- All the information on the attached completion certificate must be present on the program's certificate.
- Each nurse aide candidate must receive a **training program completion certificate after successfully completing all approved curriculum and nurse aide training program hours.**
- The certificate **must** be notarized. The instructor or program coordinator **cannot** notarize the certificate for students taught under their instructional training.
- The notary should use an ink stamp so the certificate can be copied. A copy is required with the testing application for the competency exam.
- The student's name must be printed at the top of the certificate; this is the individual that completed the nurse aide training program course.
- The approved faculty member name must go on the bottom of the certificate, this is the program faculty member validating before the Notary and had the certificates signed. **The student's name cannot be listed in the Notary section.**
- You can put the information on the attached certificate on certificate paper with a program seal, if desired.

Georgia Nurse Aide Training

This is to certify that

_____

(please print)

has successfully completed _____at

Number of Hours

a Georgia State-approved Nurse Aide Training Program at

_____

Name of Program (please print)

_____

Program Number

on the _____ day of _____, 20____.

Certified by:

_____ _____

Signature of Approved Faculty Print Name of Approved Faculty

Notary Public
Georgia
_____ County
I, _____, a
Notary Public for said County and State, do hereby certify that
_____
personally appeared before me on this day and acknowledged
the due execution of the foregoing instrument.

Witness my hand and official seal, on the _____ day of _____, 20_____.

Notary Public (Signature) My Commission Expires . 20 .

NOTE: This certificate does not guarantee that the above mentioned student will be listed by the Georgia Nurse Aide Registry. The student must successfully pass both portions of the National Nurse Aide Assessment Program (NNAAP) examination to be eligible for placement on the Georgia Nurse Aide Registry.

IMPORTANT INFORMATION
CERTIFIED NURSE AIDE
FINDINGS OF ABUSE, NEGLECT, OR MISAPPROPRIATION OF PROPERTY

The Nurse Aide Registry (NAR) includes information from Healthcare Facility Regulations regarding allegations of resident abuse, neglect or misappropriation of property made against a Certified Nurse Aide (CNA). Presently all allegations of resident abuse, neglect or misappropriation of property made against a CNA by Healthcare Facility Regulations are attached to the CNA's name on the NAR. A CNA is not allowed to work in a nursing home and/or in other healthcare facilities if the allegation is found to be true. The allegation then becomes a **PERMANENT** restriction against the CNA and imposes a non-active status on the NAR.

Generally, initial complaints are reported to Healthcare Facility Regulations by peers, supervisors, administrators, residents, resident family members or other facility workers. The Nursing Home Administrator and/or the Director of Nursing MUST report any allegations of resident abuse, neglect or misappropriation of property to Healthcare Facility Regulations.

Prior to allegation placement on the NAR:

- Healthcare Facility Regulations receives all complaints of the occurrence(s) of resident abuse, neglect or misappropriation of property;
- determines if the CNA will receive written Notice of Intent in regards to the allegation of resident abuse, neglect or misappropriation of property; and
- places the attachment of allegation(s) to the CNA's name on the NAR

Important Information to Remember:

- CNA will receive written notice from Healthcare Facility Regulations if an allegation is found to be true ;
- the CNA will have thirty (30) days to appeal the Notice of Intent letter by requesting a hearing;
- failure to respond to the Notice will result in placement of the allegation on the NAR ;
- the CNA is responsible to inform state offices of current telephone number, mailing address and/or name change ;
- if Healthcare Facility Regulations sends the Notice of Intent letter to the last known address and the CNA does not receive the letter the allegation will be placed on the NAR;
- a CNA is not allowed to appeal the decision after a period of thirty (30) days;
- a CNA may continue to work pending a decision of the appeal;
- to determine the decision a hearing will be held by an Administrative Law Judge
- if the judge finds that the CNA has indeed committed resident abuse, neglect, or misappropriation of property, the allegation is immediately placed on the NAR on the CNA's record;
- following the confirmation of resident abuse, neglect or misappropriation of property the occurrence becomes public information;
- an allegation remains on the NAR indefinitely and prevents the CNA from further employment in a Medicaid/Medicare nursing home and/or other healthcare facilities; and
- the CNA will be denied certification renewal once an confirmed allegation has been placed on the NAR

Please share this information with CNAs. All questions and/or occurrences to report regarding allegations of resident abuse, neglect or misappropriation of property against a CNA should be directed to Healthcare Facility Regulations at **404-657-5850 or 1-800-878-6442.**