Nurse Aide Training Program (NATP) Review Questionnaire

(Please Type)

Facility Name: ____

Contact Person Name: ____

Email Address: ____

Address: ____

City/State/Zip Code: _____________________ _____ ____________

County: ____

Administrator: ____

Director of Nurses: ____

Program Coordinator: ____

Staff Development Coordinator: ____

Instructors: __________________ ____________________ __________________

___________________ ____________________ ________________________

___________________ ____________________ ________________________

Review Period Dates: ________________________ **to** ___________________________

# of current trainees (in training) in class and/or clinical ____________

# of candidates that received a Certificate of Completion ____________

 # certified (passed the state competency exam) ____________

# of candidate withdrawals ____________

 # failed the NATP ____________

# of Retests ____________

# of Program Offerings ____________

# of current trainees on staff (Nursing Home Only) ____________

Current copy of the Nurse Aide Program Manual on file (Yes or No) ____________

Trainees received the Copy of the Georgia Nurse Aide Candidate Handbook (Yes or No) _____

Attestation statement: I attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission of material fact may jeopardize the status of this Georgia Nurse Aide Program.

Signature ____ **Date** _____________________