



**Oregon State Board of Nursing**  
 17938 SW Upper Boones Ferry Rd.  
 Portland, OR 97224-7012  
 971-673-0685  
[www.oregon.gov/OSBN](http://www.oregon.gov/OSBN)

# Oregon Application to Provide An NA/MA/CNA 2 Training Program

**NOTE:** Before submitting an application and fees for approval to offer an NA, MA, or CNA 2 training program in Oregon, please review the Oregon Nurse Practice Act, Division 61: *Standards for Training Programs for Nursing Assistants and Medication Aides* in order to verify that your proposed program meets the eligibility requirements. These rules are available on the OSBN website at [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN).

## Section 1: Application Instructions

- For questions regarding the application process, please call OSBN at 971-673-0640 to speak to the Nursing Policy Administrative Assistant, or you may send an email message to the OSBN practice question address at [osbn.practicequestion@state.or.us](mailto:osbn.practicequestion@state.or.us)
- Submit the completed and signed application with full payment at least 45 business days in advance of an expected program start date per Oregon Administrative Rule (OAR) 851-061-0030(3) to process your application for approval.
- Include check or money order payable to OSBN with your application based on the application type (see Application Fee table below). **All application fees are non-refundable.**

## Section 2: Application Fee Table

Application Type	Fee	Description
<b>New NA/MA/CNA 2 Training Program</b> (form EDU-730)	<b>\$100</b>	This application may be submitted by a facility, agency, online program provider, or individual(s) wishing to establish a new nursing assistant level one, level two, or medication aide training program in Oregon. All programs shall be Board-approved prior to operation per OAR 851-061-0030(2)&(3).
<b>Revised NA/MA/CNA 2 Training Program</b> (form EDU-730)	<b>\$75</b>	This same application is used when there are significant changes to a previously approved training program as defined in OAR 851-061-0030(8)(a-b) that requires subsequent review and re-approval.
Application for Designated Faculty of a NA/MA/CNA 2 Training Program (form EDU-735)	<b>\$25/\$10</b>	This application must be submitted with a <b>NEW</b> training program application <u>for each</u> training program faculty member.

## Section 3: Application Checklist

Please review the following checklist items to ensure that you are submitting a completed application for processing.

- All sections of the application form EDU-730 are complete, and the authorization section is signed and dated. **Submit original application to OSBN-** copies are not accepted and will delay processing.
- Submit payment by check or money order made payable to the Oregon State Board of Nursing with your application materials.
- Include all applicable supplemental documentation required, listed in page two, Section 4 of the application to ensure all components of the program are evaluated during for review and subsequent approval.

**Mail all application materials and form of payment to:**

**Oregon State Board of Nursing  
 17938 SW Upper Boones Ferry Rd  
 Portland OR 97224**

**Notice to Applicants with Disabilities:** If you have a disability and require special materials or assistance to complete this application, please contact OSBN at 971-673-0685. If you are hearing impaired, you may contact OSBN through the Oregon Relay Service at 1-800-735-2900.



# Information for Oregon Application for NA/MA/CNA 2 Training Program Approval

## **Section 4: Required Supplemental Documentation**

In addition to submitting the application form EDU-730 and processing fee(s) for initial approval of a new training program, per OAR 851-061-0030(3) the following types of supplemental documentation must be included.

1. Form **EDU-735** *Oregon Application for Designated Faculty of an NA/MA/CNA 2 Training Program* completed for each faculty member AND **EDU-736** *Guidelines for LPN Clinical Teaching Associates of an NA/MA/CNA 2 Training Program* completed for each LPN faculty member.
2. Program rationale, philosophy, and purpose
3. **Curriculum outline** that includes the following:
  - a. Program Name
  - b. Objectives
  - c. Curriculum content that is divided into number and sequence of didactic and clinical hours
  - d. Teaching methodology
4. **Enrollment agreement and disclosure statement** that includes:
  - a. Beginning and ending dates of the training
  - b. Outline of the instructional program
  - c. Itemized separate lists of fees, tuition, and other program costs (including books, clothing, etc)
  - d. A published cancellation and refund policy with procedure and schedule that is fully explained during orientation, and requires no less than:
    - i. If training program is discontinued after payment of fees and tuition, the program must refund the tuition and fees in full, if the closure occurs before the course is completed; and
    - ii. If a student cancels enrollment in writing three days before commencement of the first day of classes, or three days before they receive access to online didactic training, all tuition and fees paid to the program specific to the enrollment agreement, will be refunded, minus a cancellation fee that cannot exceed ten percent of the tuition and fees paid; and
    - iii. Clearly stated reasons for which a refund will not be granted.
  - e. Information on how to file a complaint against the program with OSBN
  - f. Tentative timeframe for implementation towards start date of program
  - g. Plan for job placement assistance if provided by program
5. Evaluation method- **Laboratory and clinical skills checklist**
6. Evaluation method- **Final examination**

## **Section 5: Training Program Approval and Re-Approval Process**

Submit application, applicable fees, and documentation 45 days before prospective start date. OSBN approval must be received prior to operation of the program.

1. Designated program director will be notified of program approval or denial. Programs that receive a denial are notified of deficiencies, and have the option for re-evaluation after modifications are made and/or submission of a petition.
2. Programs approved will receive an on-site survey visit conducted by the OSBN Nursing Assistant Policy Analyst within six months of the program's initial approval.
3. To receive continued approval, the program shall demonstrate ongoing compliance with standards of initial approval at least every two years, by survey visit conducted by the OSBN Nursing Assistant Policy Analyst.
4. The program will complete a self-evaluation form provided by OSBN during the interim between the initial and renewal site visits to demonstrate compliance.
5. The program is subject to scheduled or non-scheduled site visits conducted by OSBNI.
6. If there are major changes to the program (listed below), Board review for approval is required.
  - a. Change of program ownership; and/or changes in course content, lab/clinical skill checklist, final exam, certificate of completion, program director, primary instructor, clinical teaching associate, attendance policies and procedures, course requirements, cancellation and refunds, or classroom or clinical training sites.



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**NOTE:** Use only black or blue ink and print all information legibly. Submit original- faxed or emailed applications are not accepted.

**Section 1: Training Program Type-** All sections must be completed in order to process application.

A: Application Type	B: Program Type
<input type="checkbox"/> <b>New</b> Program Approval Review- <b>\$100</b>	<input type="checkbox"/> Nursing Assistant (NA 1) Program
<input type="checkbox"/> <b>Revised</b> Program Approval Review- <b>\$75</b>	<input type="checkbox"/> CNA 2 Program
	<input type="checkbox"/> Medication Aide (MA) Program

**Section 2: General Program Information**

Program Name:		
Physical Address:		
Mailing Address:(if different)		
City:	State:	Zip:
Primary Telephone: <input type="checkbox"/> Unlisted	Email:	

**Section 3: Person Authorized to Accept Board Notifications**

List below the authorized contact person that is on file with the Oregon Secretary of State's office.

Primary Contact (Director or Designee)		
Last Name:	First Name:	MI
Mailing Address:		
City:	State:	Zip:
Primary Telephone:	Position Title:	

**Section 4: Program Faculty Information**

Program Director	
Printed Name:	Signature & Date:
Oregon RN License Number:	License Exp Date: (mm/dd/yy)
Primary Instructor	
Printed Name:	Signature & Date:
Oregon RN License Number:	License Exp Date: (mm/dd/yy)

## Section 5: Program Training Sites

1. Classroom Instruction Site(s)- list below all classroom site(s) that will be utilized in the program.

Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Community College <input type="checkbox"/> High School	<input type="checkbox"/> Hospital <input type="checkbox"/> Job Corps	<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Private	<input type="checkbox"/> Residential Care Facility
Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Community College <input type="checkbox"/> High School	<input type="checkbox"/> Hospital <input type="checkbox"/> Job Corps	<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Private	<input type="checkbox"/> Residential Care Facility
Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Community College <input type="checkbox"/> High School	<input type="checkbox"/> Hospital <input type="checkbox"/> Job Corps	<input type="checkbox"/> Nursing Facility <input type="checkbox"/> Private	<input type="checkbox"/> Residential Care Facility

2. Supervised Clinical Practice Site(s)- list below all clinical site(s) that will utilized in the program. If needed, include any additional sites on a separate page of paper.

Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Residential Care Facility	
Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Residential Care Facility	
Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Residential Care Facility	
Facility Name				
Physical Address		City		Zip
Primary Telephone		Email		Fax
<b>Facility Type:</b> (select one) <input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Residential Care Facility	

**Section 6: Program Course Materials**

List the course materials that would be used in the training program based on type of media.

1. Textbooks

Title:		
Author:	Publisher:	Year: (mm/dd/yy)
Title:		
Author:	Publisher:	Year: (mm/dd/yy)
Title:		
Author:	Publisher:	Year: (mm/dd/yy)

2. Audio Visuals

Title:	
Production Company:	Release Date: (mm/dd/yy)
Title:	
Production Company:	Release Date: (mm/dd/yy)
Title:	
Production Company:	Release Date: (mm/dd/yy)

3. Other Supplemental Materials or Sources of Instruction

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Section 7: Authorization**

I certify that the information provided on this completed application and all supplemental documentation is true and correct .I am aware that falsifying an application, supplying misleading information, or withholding information is grounds for denial of this application.

Director's  
Signature

Date Signed  
(mm/dd/yy)

**OSBN USE ONLY-** Training & Assessment Policy Analyst Review for Approval

Approved      Date (mm/dd/yy): \_\_\_\_\_ OSBN Policy Analyst Signature: \_\_\_\_\_

Denied      Date (mm/dd/yy): \_\_\_\_\_ Notes: \_\_\_\_\_

Notification Sent