



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 for Designated Faculty of an NA/MA/CNA 2 Training Program

**NOTE:** Before submitting an application and fees for a faculty member of an Oregon NA, MA, or CNA 2 training program, please review the Oregon Nurse Practice Act, Division 61: *Standards for Training Programs for Nursing Assistants and Medication Aides* and Division 63 *Standards and Authorized Duties for the Certified Nursing Assistant and Certified Medication Aide* in order to verify that program faculty meet 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)
- Authorization to teach is specific to the individual program and site. Instruction by the applicant may only begin after receiving Board 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
Application for Designated Faculty of NA/MA/CNA 2 Training Program (form NA-735)		See Below	This application is REQUIRED to be submitted by the training program to designate the qualified program director, primary instructor, and additional clinical faculty. <b>A separate application form and fee is required for each faculty member per position type listed below.</b>
Fees per Type:	<b>\$25</b> Program Director	<b>\$10</b> Primary Instructor	<b>\$0</b> Clinical Teaching Associates

## 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 735 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 a copy of your professional resume with the completed application and processing fee.

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.



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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: Faculty Position Type & Fees- Check all boxes that apply.

<b>A: Nursing Assistant</b>	<b>B: Medication Aide</b>	<b>C: CNA 2</b>
<input type="checkbox"/> Program Director \$25 <input type="checkbox"/> Primary Instructor \$10 <input type="checkbox"/> Clinical Teaching Associate (no fee)	<input type="checkbox"/> Program Director- \$25 <input type="checkbox"/> Primary Instructor- \$10 <input type="checkbox"/> Clinical Teaching Associate (no fee)	<input type="checkbox"/> Program Director- \$25 <input type="checkbox"/> Primary Instructor- \$10 <input type="checkbox"/> Clinical Teaching Associate (no fee)
<b>C: List the Training Program you are associated with:</b>		
Program Name: _____ Program Director: _____		

## Section 2: Name and Address Information

Last Name:		First Name:		MI
Mailing Address:			Date of Birth (mm/dd/yy):	
City:		State:	Zip:	
Primary Telephone:		Email:		
Oregon LPN/RN License Number:		License Exp Date: (mm/dd/yy)		

## Section 3: Nurse Education- List below the initial nurse education that qualified you to practice nursing, and any nursing degree/certificate(s) received thereafter.

Name of School		
City	State	Graduation Date (mm/dd/yy):
<input type="checkbox"/> Practical/Vocational Nurse Certificate <input type="checkbox"/> Nursing Program Diploma	<input type="checkbox"/> Associate's Degree in Nursing <input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing <input type="checkbox"/> Doctorate Degree in Nursing
Name of School		
City	State	Graduation Date (mm/dd/yy):
<input type="checkbox"/> Practical/Vocational Nurse Certificate <input type="checkbox"/> Nursing Program Diploma	<input type="checkbox"/> Associate's Degree in Nursing <input type="checkbox"/> Bachelor's Degree in Nursing	<input type="checkbox"/> Master's Degree in Nursing <input type="checkbox"/> Doctorate Degree in Nursing

## Section 4: Nurse Employment

Employer Name:		Telephone:		
Physical Address:		City:	State:	Zip:
Position Title:		License Number Used		Licensing State:
Still Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date (mm/dd/yy):		End Date (mm/dd/yy):	
Paid Practice: <input type="checkbox"/> Yes <input type="checkbox"/> No				

**Section 5: Qualifying Experience for Director/Primary Instructor**

My professional resume is included with application as required.

List below courses, instruction, and/or experience that have prepared you to direct/instruct a training program in Oregon per OAR 521-061-0080(1) for directors and 0080(4) for instructors.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Section 6: Program Responsibilities of a Clinical Teaching Associate**

**NOTE: Only complete this section** if you are submitting this application as a designated Clinical Teaching Associate.

Indicate below your understanding of what your role/duty will be as a clinical teaching associate for the training program.

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I have received a job description from the director of this training program and understand what my responsibilities are as a designated Clinical Teaching Associate.

**Section 7: Authorization by the Applicant and Program Director**

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.

Applicant  
Signature

Date Signed  
(mm/dd/yy)

I as the Program Director (if not the applicant), have reviewed this application and find that the applicant meets qualifications set forth by the Oregon State Board of Nursing in order to fulfill the position(s) indicated in this application. My signature authorizes my recommendation that this individual be approved for this program.

Director's  
Signature

Date Signed  
(mm/dd/yy)

<b>OSBN USE ONLY- Training &amp; Assessment Policy Analyst Review for Approval</b>		
<input type="checkbox"/> Approved	Date (mm/dd/yy): _____	OSBN Policy Analyst Signature: _____
<input type="checkbox"/> Denied	Date (mm/dd/yy): _____	Notes: _____
<input type="checkbox"/> Notification Sent		
Qualified Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ LTC Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Required		