



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road, Portland, Oregon 97224-7012

• Phone: 971-673-0685 • Fax: 971-673-0684

• E-mail: oregon.bn.info@state.or.us • Website: www.oregon.gov/OSBN

Nursing Assistant, Medication Aide or CNA2 Training Program Approval Information

PART ONE

Forms to be completed and returned to the OSBN:

- Application for Approval to Offer a Nursing Assistant, Medication Aide or CNA2 Training Program
- Description of Course Materials
- Application for Nursing Assistant, Medication Aide or CNA2 Training Program Instructor
- LPN Clinical Preceptor Guidelines (*Required for every LPN Clinical Preceptor application*).

Required information to include with forms:

- Program rationale, philosophy, and purpose
- A curriculum outline including program title, objectives, curriculum content divided into number and sequence of didactic and clinical hours, and teaching methodology (See sample in Part 2).
- A copy of the Lab/Clinical Skills Checklist form (See samples in Part 2)
- A copy of the final exam
- For CNA2 training programs: A copy of a Certificate of Completion
- Tentative scheduled start dates of training program

PART TWO

Forms and information for use in a training program:

- Sample format for Curriculum Outline
- Approved CPR Certification for Nursing Assistant Training Programs
- Sample Lab/Clinical Skills Checklist for Nursing Assistant Training Program
- Sample Lab/Clinical Skills Checklist for CNA2 Training Program
- Sample Lab/Clinical Skills Checklist for Medication Aide Training Program
- Sample Medication Aide Program Clinical Time Sheet
- Sample Student Record
- Equipment, and supplies
- Course Summary form for CNA2 Training Program

PART THREE

Links (Control/Click to follow link)

- [Curriculum Content for Nursing Assistant Training Programs](#)
- [Curriculum Content for Medication Aide Training Programs](#)
- [Curriculum Content for CNA2 Core](#)
- [Curriculum Content for CNA2 Acute Care](#)
- [Curriculum Content for CNA2 Dementia Care](#)
- [Curriculum Content for CNA2 Restorative Care](#)
- [Facility Credit Card Form](#)
- [Headmaster Web page](#)
- [Medication Aide \(MA\) Examination Application Packet](#)
- [Nursing Assistant \(NA1\) Examination Application Packet](#)
- [OAR Division 61](#)
- [OAR Division 62](#)
- [OAR Division 63](#)
- [Test Accommodation Policy](#)
- [Training Program List \(Updated Monthly\)](#)

PART 1



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Application for Approval to Offer Nursing Assistant, Medication Aide or CNA2 Training Program

Initial Approval \$100.00 Non-refundable Fee Revised Approval \$75.00 Non-refundable Fee

Allow 45 Days for Approval Process

Form with checkboxes for Nursing Assistant (NA1) Program, Med Aide (MA) Program, CNA 2 Program, Acute Care, Dementia Care, and Restorative Care.

Name of Program Date of Application (mm/dd/yyyy)

Program Street Address City State Zip Code

County:

()

Area Code Program Telephone Number Email Address

Last Name of person authorized to accept service of notice First Name MI

Mailing Street Address of authorized person City State Zip Code

()

Area Code Telephone of authorized person E-mail (Optional)

Print Program Director's Name Clearly Signature of Program Director Date of Signature

Print Primary Instructor's Name Clearly Signature of Primary Instructor Date of Signature

For official use ONLY:

Date of Initial Approval Signature Date of Site Survey Signature (repeated 5 times)

Changes, Updates, Etc...

Date Information (repeated 3 times)



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Description of Course Materials

Attach to Application for Approval to Offer NA, MA or CNA2 Training Program

Classroom Site

Facility Name: _____

Facility Address: _____

Facility Telephone Number: () _____

Supervised Clinical Practice Site(s)

Facility Name: _____

Facility Address: _____

Facility Telephone Number: () _____

Facility Name: _____

Facility Address: _____

Facility Telephone Number: () _____

Facility Name: _____

Facility Address: _____

Facility Telephone Number: () _____

Text Books(s)

Title: _____

Author(s): _____

Publisher: () _____

Title: _____

Author(s): _____

Publisher: () _____

Videos

Title: _____

Producer/Co: _____

Title: _____

Producer/Co: _____

Title: _____

Producer/Co: _____

Other Supplemental Materials or Sources of Instructions

Agreement

Applications must be submitted to the Board of Nursing for approval before the start of the first class. The Oregon State Board of Nursing (OSBN) Nursing Assistant Program Consultant shall conduct a site visit within six months of the training programs initial approval. The Program must be re-approved every two (2) years thereafter, during a renewal survey, to continue as a training program. A training program self-evaluation must be completed in the interim between renewal surveys.

If there are major changes in the course, an updated form must be submitted for approval. Major changes include:

- Changes in classroom or clinical site(s)
- Changes in Program Director or Primary Instructor
- Changes in textbook and/or course structure

I hereby certify that I have read this application and accompanying information and forms. The application, and all accompanying information and forms, is true and correct.

Program Director's Signature

Date



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Nursing Assistant, Medication Aide or CNA2 Training Program Instructor/Director Application

Check all items below that apply and attach appropriate non-refundable fee(s) with application.

Nursing Assistant

- Program Director \$25
- Primary Instructor \$10
- Clinical Preceptor *No fee*
- Clinical Instructor *No fee*

Medication Aide

- Program Director \$25
- Primary Instructor \$10
- Clinical Preceptor *No fee*

CNA2

- Program Director \$25
- Primary Instructor \$10
- Clinical Preceptor *No fee*
- Clinical Instructor *No fee*

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AC | DC | RC |
| \$25 | \$25 | \$25 |
| \$10 | \$10 | \$10 |
| <i>No fee</i> | <i>No fee</i> | <i>No fee</i> |
| <i>No fee</i> | <i>No fee</i> | <i>No fee</i> |

Last Name _____ First Name _____ Middle Name _____

Mailing Street Address _____ City _____ State _____ Zip Code _____

()

Area Code _____ Home Telephone _____ Unlisted _____ E-mail _____

Social Security Number _____

RN LPN

License Number _____ License Type _____ Expiration Date _____

Training Program Name _____ Program Director Name _____

Current Employer Name _____ ()
Area Code _____ Employer Telephone Number _____

Employer Street Address _____ City _____ State _____ Zip Code _____

YES NO

Start Date _____ Still Employed? _____ If not employed, End Date _____

Duties _____ Job Title _____

Official Use Only

Expiration Date: _____

Approved: YES NO

Status: _____

Signature: _____

Experience: YES NO

Date Approved: _____

LTC met: YES NO

Train-- the -- Trainer Required YES NO

Previous Employer Name () Area Code Employer Telephone Number

Employer Street Address City State Zip Code

YES NO

Start Date Still Employed? If not employed, **End Date**

Duties Job Title

Basic School of Nursing Degree Earned Date Graduated

Other Academic School of Nursing Degree Earned Date Graduated

Other Academic School of Nursing Degree Earned Date Graduated

Other courses/instruction/experience that have prepared you to Direct/Instruct a NA or MA training program:
(See OAR 851-061-0080 (1) for Program Director Qualifications, and OAR 851-061-0080 (4) for Primary Instructor Qualifications).

1. _____
2. _____
3. _____

Responsibilities For Clinical Instructors and Preceptors ONLY	
What do you understand your role/duty will be as a clinical instructor or clinical preceptor?	
_____ _____	
I have received a job description from the Program Director of this program and understand what my responsibilities are as a clinical instructor or clinical preceptor.	
_____ <i>Signature of Applicant Clinical Instructor or Clinical Preceptor</i>	_____ <i>Date</i>

I hereby certify that I have read this application and further certify that the information provide on this form is true and correct.

Signature of Applicant *Date*

Attach Resume (If LPN also attach the LPN Clinical Preceptor Guidelines form)

*** Authorization to Teach is Program and Site Specific ***
You may begin classes after receiving approval from the Oregon State Board of Nursing (OSBN).

I, the Program Director, have reviewed this application.	
_____ <i>Signature of Program Director</i>	_____ <i>Date</i>



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LPN Clinical Preceptor Guidelines

(SIGN AND ATTACH TO APPLICATION)

As a Clinical Preceptor, the LPN may:

- 1) Assist with the clinical portion of the Nursing Assistant and Medication Aide Training. This includes:
 - A) Provide demonstration of Clinical Skills.
 - B) Check students off on return demonstration of Lab Skills prior to Client care.
 - C) Check students off on skills in a supervised Clinical setting while giving Client care.
- 2) Supervise quizzes and exams.

As a Clinical Preceptor, the LPN may not:

- 1) Conduct full class days (or evenings).
- 2) Provide the complete lecture in any given module or topic **UNLESS** he/she has submitted to the Board Evidence of special expertise in a particular area, and the Board has approved that LPN to teach that given topic.
- 3) Conduct and have responsibility for the Clinical portion of the Program.
- 4) Be used in any capacity in the training program without written approval from the Board.

Program Name: _____
Print Name

Primary Instructor: _____
Print Name

Primary Instructor: _____
Instructor Signature _____
Date

LPN Clinical Preceptor: _____
Print Name

LPN Clinical Preceptor: _____
LPN Signature _____
Date

PART 2



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OSBN Approved CPR Certification for Nursing Assistant Training Programs

Effective 3/2004

The Board approved CPR certification shall be a minimum of:

- Basic Life Support for Health Care Providers from the American Heart Association; or
- CPR/AED for the Professional Rescuer from the American Red Cross.

May be:

- A condition of admission into the Nursing Assistant Training Program; or
- A condition of completion of the Nursing Assistant Training Program; or
- Part of the curriculum of the Nursing Assistant Training Program.

Required record-keeping:

- The Nursing Assistant Training Program must determine that each student who completes the program has current CPR certification; and
- The Nursing Assistant Training Program must keep this information as part of the individual student records.



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Sample Curriculum Outline

Program Name: _____

September 1, 2010

Day and Hours	Objectives	Curriculum Content	Teaching Methodology
Day 1 5 hours	1) The student will be able to list the common duties and responsibilities of a CNA. 2)	1) The role of a CNA as a member of a health care team; (a) Authorized duties of the CNA. (b)	1) Textbook; Read Chapter 1 Pages 4 – 19 2) Lecture and discussion 3) Role Play
Day 2 8 hours			

Preferred format is 8.5" X 11" paper with text oriented by "Landscape"



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NA Lab/Clinical Skills Checklist

Program Name: _____

Student Legal Name: _____

Lab: This practice must be under the supervision of a Board-approved instructor/preceptor in the skills lab on a mannequin or another person.

Clinical: The student must successfully demonstrate the skills, to a Board approved clinical instructor/preceptor, on a client, patient, or resident in the clinical setting.

Bolded skills should be done in lab and clinical.

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Communications					
Infection Control and Standard Precautions					
Wash hands/hand hygiene					
Follow standard precautions according to the Centers for Disease Control and Prevention					
Assist with coughing and deep breathing					
Handle linen					
Make an occupied bed					
Make an unoccupied bed					
Put on and removing personal protective equipment: gloves					
Put on and removing personal protective equipment: gown					
Put on and removing personal protective equipment: mask					
Collect a clean catch urine specimen					
Collect a sputum specimen					
Collect a stool specimen					
Safety/Emergency Procedures					
Administer abdominal thrust (Heimlich Maneuver)					

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Ambulate using a gait belt					
Ambulate with a cane					
Ambulate with a walker					
Apply a wrist restraint					
Apply position/alignment techniques for clients in bed using safe client handling devices					
Position/alignment techniques for clients in chairs and wheelchairs using safe client handling devices					
Transfer client from bed to wheelchair					
Transfer client from wheelchair to bed					
Turn oxygen on and off at pre-established flow rate for stable client					
Use safe client transfer and handling techniques with lift equipment					
Use safe client transfer and handling techniques with seated transfers					
Nutrition and Hydration					
Assist with a meal					
Assist with hydration					
Elimination					
Assist with the use of a fracture pan					
Assist with the use of a regular bedpan					
Assist with use of a toilet					
Assist with use of a urinal					
Change of a disposable brief					
Change from a drainage bag to a leg bag					
Change from a leg bag to a drainage bag					
Clean ostomy site for established, non-acute ostomy					
Empty ostomy bag or change ostomy bag which does not adhere to the skin					
Give an enema					

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Insert a bowel evacuation suppository					
Provide catheter care including the application of and removal of external urinary catheters					
Personal Care					
Put on and care for eyeglasses					
Put in and care for hearing aids					
Apply anti-embolism elastic stockings					
Apply non-prescription pediculicides					
Apply topical, non-prescription barrier creams & ointments for prophylactic skin care					
Assist with hair care/shampoo					
Dress/undress					
Give a bed bath					
Give shower bath					
Provide denture care					
Provide fingernail care					
Provide foot care					
Provide mouth care					
Provide mouth care for a comatose client					
Provide perineal/incontinence care					
Provide skin care					
Shave face with electric razor					
Shave face with safety razor					
Restorative Care					
Assist with lower extremity range of motion					
Assist with upper extremity range of motion					
Measure and Record					
Height					
Weight					
Input					
Output					
Pain level					
Temperature					
Apical pulse					
Radial pulse					

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Respirations					
Electronic blood pressure					
Manual blood pressure					
Orthostatic blood pressure readings					
Pulse oximetry					

Student Signature _____ Date _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____



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CNA-2 Core and Acute Lab/Clinical Skills Checklist

Program Name: _____

Student Legal Name: _____

Lab: This practice must be under the supervision of a Board-approved instructor/preceptor in the skills lab on a mannequin or another person.

Clinical: The student must successfully demonstrate the skills, to a Board approved clinical instructor/preceptor, on a client, patient, or resident in the clinical setting.

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator		Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
CORE						
Interpersonal Skills/Communication						
Communication techniques						
Active listening						
Reflecting						
Rephrasing						
Supportive presence						
Learning principles						
Observation and Reporting						
Identify manifestations of pain						
Verbalize report of pain						
Technical Skills						
Adding fluid to established Tube feedings						
Change established tube feeding bags						
Apply SCDs						
Assist with warm & cold therapies						
Bladder Scanning						
Fingerstick capillary blood testing						
Interrupting & re-establishing NG suction						
Reinforce use of Incentive spirometer						

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator		Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Suction oral pharynx						
Taking vital signs						
Pulse – electronic						
Blood pressure:						
<i>Manual</i>						
Forearm						
Upper arm						
Thigh						
Lower leg						
<i>Electronic</i>						
Forearm						
Upper arm						
Thigh						
Lower leg						
Orthostatic blood pressure						
Test stool for occult blood						
Urine dip-stick test						
Infection Control						
Change dressing or ostomy appliance/bag which adheres to the skin						
Obtain sterile urine specimen from port of catheter						
Discontinue Foley catheter						
Measuring, recording and/or emptying output from drainage devices and closed drainage systems						
Perform clean intermittent straight urinary catheterization for chronic conditions						
Safety						
Articulate NPSG						
Recognize at-risk behavior						
ACUTE						
Observation & Reporting						
<i>Technical Skills</i>						
Obtain rectal swab						
Place electrodes/leads for telemetry						
Place electrodes/leads & run electrocardiogram (EKG)						

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator		Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Test gastric contents for occult blood or pH						
CPM				OR		
Remove casts in non emergent situations						
Set up traction equipment						
Documentation						
Use terminology accurately						
Use abbreviation appropriately						

Student Signature _____ **Date** _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____



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Medication Aide Lab / Clinical Skills Checklist

Program Name: _____

Student Legal Name: _____

Lab: This practice must be under the supervision of a Board-approved preceptor in the skills lab on a mannequin or another person.

Clinical: The student must successfully demonstrate the skills, to a Board approved clinical preceptor, on a client, patient, or resident in the clinical setting.

Skills must be done in lab before giving direct patient care.

Skills	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Follow standard precautions including hand hygiene according to the Centers for Disease Control and Prevention guidelines					
Prepares for medication administration					
Correctly interprets abbreviations					
Calculates dosages correctly					
Consistently identifies specific drug properties of drug being given: Classification, Dose, and Side Effects					
Checks for known medication allergies before administering medication					

Skill	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Checks the expiration date of the medication before administering					
Uses organized system for passing medications					
Protects confidentiality					
Follows correct medication administration procedures (Five rights): Right resident, drug, dose, route, and time					
Measures liquid medications accurately					
Properly administers medications by oral route					
Properly administers medications by sublingual route					
Properly administers medications by buccal route					
Properly administers medications in eye					
Properly administers medications in ear					
Properly administers medications by nasal route					
Properly administers medications by rectal route					
Properly administers medications by vaginal route					
Properly administers skin ointments, topical including patches and transdermal					

Skill	Date Demonstrated	Date Return Demonstrated in Lab	Signature/ Initial Nurse Evaluator	Date Return Demonstrated in Clinical	Signature/ Initial Nurse Evaluator
Properly administers medications by gastrostomy or jejunostomy tubes					
Properly administers premeasured medication delivered by aerosol/nebulizer					
Properly administers medications by metered hand-held inhalers					
Observes client swallowing medication					
Consults resources (drug reference books, nurse, etc) as needed					
Maintains security of medication room and cart					
Accurately documents medication administration					
Demonstrates appropriate reporting to nurse					

Student Signature _____ **Date** _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____

Instructor Signature _____ Initial _____ Date _____



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Training program labs shall have equipment and supplies needed for student practice of all required skills and be available for the students' and instructor's use during instructional hours throughout the training period.

ITEM	YES	NO	COMMENTS
ADJUSTABLE BED WITH SIDERAILS			
ALCOHOL/ANTISEPTIC WIPES			
ANTIEMBOISM ELASTIC STOCKINGS			
BATH BLANKET			
BEDPAN			
BEDSIDE COMMODORE			
BEDSIDE STAND			
CALL BELL (DOES NOT HAVE TO BE WORKING)			
CANE			
CATHETER CLAMP, CAP AND PLUG			
CLOTHING OF VARIOUS SIZES			
DENTURES & DENTURE CONTAINER			
DIGITAL THERMOMETER WITH SHEATHS			
DISPOSABLE BRIEFS			
DISPOSABLE GLOVES			
EMERY BOARDS			
EMESIS BASIN			
FOLEY CATHETER			
FOOD TRAY, PLATE, SILVERWARE			
GAIT BELT/TRANSFER BELT			
GRADUATE			
HAND WASHING SINK WITH RUNNING WATER, SOAP AND PAPER TOWELS			
LAUNDRY RECEPTACLE			
LINENS INCLUDING PILLOWS, PILLOW CASES, FLAT SHEETS, FITTED SHEETS, DRAW SHEETS, INCONTINENCE PADS, BED SPREADS, TOWELS, WASH CLOTHS, BATH BLANKETS, CLOTHING PROTECTORS AND PATIENT GOWNS			
LOTION			
MANNEQUIN (ANATOMICALLY CORRECT)			
MECHANICAL LIFT			
MOUTHWASH SOLUTION			
NAIL CLIPPERS			
ORANGEWOOD STICKS			
OXIMETER			
OVERBED TABLE			

ITEM	YES	NO	COMMENTS
PRIVACY CURTAINS			
RESTRAINTS (WRIST)			
SAFETY RAZORS			
SAMPLE FOOD ITEMS AND NAPKIN (CANNED APPLESAUCE, ETC...)			
SHAVING CREAM			
SCALE			
SOAP			
SPHYGMOMANOMETER			
TEACHING STETHOSCOPE			
TOILET PAPER			
TOOTHBRUSH/TOOTHETTES			
TYMPANIC THERMOMETER			
URINAL			
URINARY BEDSIDE DRAINAGE BAG			
URINARY LEG BAG			
WALKER			
WASH BASIN			
WASTE BASKET			
WATCH WITH SECOND HAND			
WHEELCHAIR WITH BRAKES AND FOOTRESTS			



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CNA 2 Course Summary

Within 14 days after the end of the class the Training Program Director or Primary Instructor must complete the Course Summary form providing required information in **all** columns (do not use ditto ("") marks). Email the form, as an attachment, to the OSBN at osbn.cna@state.or.us.

The file name should be: *ProgramName_ProgramDirectorLastName_DateSubmitted.doc*

(For Example: *EVERGREEN_WILSON_20060626.doc*). Please Note: *This form must be completed and emailed as a Word document.*

This form is available as a Word template on the OSBN website at: <http://www.oregon.gov/OSBN/forms.shtml>. Scroll to "NA/MA Education Forms".

Program Name: _____ CNA2 Category: _____

Start Date of Class: _____ Number of Students Starting Class: _____

End Date of Class: _____ Number of Students Completing Class: _____

Training Program Director or Primary Instructor: _____ Date: _____

***Example:** *This entry is an example of the type of data that should be emailed for each student submitted.*

	Last Name	First Name	MI	CNA1 Certificate #	Grad	Date of Completion	#Class Hours	#Clinical Hours
*	Smith	Jenna	L	200801234CNA	Y	11-29-2006	75	75
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

	Last Name	First Name	MI	CNA1 Certificate #	Grad	Date of Completion	#Class Hours	#Clinical Hours
15								
16								
17								
18								
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