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

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

## Section 1: Required Supplemental Documentation

In addition to the application form the following types of supplemental documentation must be included per OAR 851-061-0030(3).

1. Form **EDU-735** *Oregon Application for Designated Faculty of an NA/MA/CNA 2 Training Program* completed for each faculty member
2. Form **EDU-736** *Guidelines for LPN Clinical Teaching Associates of an NA/MA/CNA 2 Training Program* completed for each LPN faculty member.
3. Program rationale, philosophy, and purpose
4. **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
5. **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
6. Evaluation method- **Laboratory and clinical skills checklist**
7. Evaluation method- **Final examination**

## Section 2: Training Program Approval and Re-Approval Process

Submit application 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 OSBN.
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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# Oregon Application to Provide An NA/MA/CNA 2 Training Program

**NOTE**: You may fill out the form electronically in Adobe Acrobat Reader. This form has Adobe electronic signature capability. If you are the Director and have your own Adobe electronic signature, you may use it on this form for authorization. Otherwise, you will need to provide a handwritten signature and date.

Mail application to: 17938 SW Upper Boones Ferry Rd, Portland, OR 97224. OR email to: heather.primus@osbn.oregon.gov OR debra.buck@osbn.oregon.gov

## Section 1: Training Program Type

| A: Application Type | B: Program Type |
|---|---|
| ☐ **New** Program Approval Review | ☐ Nursing Assistant (NA 1) Program<br>☐ CNA 2 Program<br>☐ Medication Aide (MA) Program |
| ☐ **Revised** Program Approval Review | |

## Section 2: General Program Information

| | | | | |
|---|---|---|---|---|
| Program Name: | | | | |
| Street Address: | | | | |
| Mailing Address: (if different) | | | | |
| City: | | State: | | Zip: |
| Primary Phone: | | 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 Agent Registered with Secretary of State) | | | | |
|---|---|---|---|---|
| Last Name: | | First Name: | | MI |
| Mailing Address: | | | | |
| City: | | State: | | Zip: |
| Primary Phone: | | Position Title: | | |

## Section 4: Program Faculty Information

| **Program Director** | | | | |
|---|---|---|---|---|
| Printed Name: | Signature: | | Date: | |
| Oregon RN 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 | |
| **Facility Type:** (select one) | | | | | |
| Facility Name | | | | | |
| Physical Address | | City | | Zip | |
| Primary Telephone | | Email | | Fax | |
| **Facility Type:** (select one) | | | | | |
| Facility Name | | | | | |
| Physical Address | | City | | Zip | |
| Primary Telephone | | Email | | Fax | |
| **Facility Type:** (select one) | | | | | |

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 | |
| **Facility Type:** (select one) | | | | | |
| Facility Name | | | | | |
| Physical Address | | City | | Zip | |
| Primary Telephone | | Email | | Fax | |
| **Facility Type:** (select one) | | | | | |
| Facility Name | | | | | |
| Physical Address | | City | | Zip | |
| Primary Telephone | | Email | | Fax | |
| **Facility Type:** (select one) | | | | | |
| Facility Name | | | | | |
| Physical Address | | City | | Zip | |
| Primary Telephone | | Email | | Fax | |
| **Facility Type:** (select one) | | | | | |

## 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: | | Publication Date: | |
| Title: | | | | | |
| Author: | | Publisher: | | Publication Date: | |
| Title: | | | | | |
| Author: | | Publisher: | | Publication Date: | |

2. Audio Visuals

| | | | |
|---|---|---|---|
| Title: | | | |
| Production Company: | | Release Date: | |
| Title: | | | |
| Production Company: | | Release Date: | |
| Title: | | | |
| Production Company | | Release Date: | |

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