NURSE AIDE TRAINING PROGRAM PRIMARY INSTRUCTOR APPLICATION

- The US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) authorizes the Department of Health Services to review and determine eligibility for nurse aide primary instructors under the requirements of the Medicare and Medicaid programs. Completion of this form is voluntary; however, the information collected on this form is used to determine if federal and state primary instructor eligibility requirements have been met.

- Complete and mail this form to: **Division of Quality Assurance**
  Bureau of Education Services and Technology
  ATTN: Wisconsin Nurse Aide Training Consultant
  P.O. Box 2969
  Madison, WI 53701-2969

- **Print neatly in BLACK INK or TYPE the following information.**

I. PERSONAL INFORMATION

Provide the following:

- Copy of your current Wisconsin nursing license
- Copy of your resume to verify your education, work history, and clinical experience in meeting clients' psychosocial, behavioral, cognitive, and physical needs
- Copy of your Train the Trainer certificate
- Copy of your orientation plan
- Copy of your completed DHS form, F-82064, *Background Information Disclosure (BID)*; Department of Justice (DOJ) Criminal History response; and DHS responses to Caregiver Background Check letter.

NOTE: To be approved as a primary instructor, state and federal regulations require that you have a minimum of two years of experience working as a registered nurse, of which at least one year must be in the provision of long term care facility services.

Full Name (Last, First, Middle Initial) --- ***DO NOT USE NICKNAMES.***			Wisconsin Nursing License No.
Current Mailing Address (Street Address / P.O. Box)	City	State	Zip Code
Telephone No.	Work Telephone No.	Email Address	
Name of the Training Program You Intend to Instruct			

II. EDUCATION

School / College	Year – Graduation
School / College	Year – Graduation
School / College	Year – Graduation
Train the Trainer Course	Date – Graduation
Substantially Equivalent Training Course Description	Date – Training Graduation

III. HEALTH CARE EMPLOYMENT INFORMATION

List the names and locations of all health care facilities at which you have been employed as a registered nurse, as well as the dates of employment. Check the appropriate box to indicate the type of health care facility.

NOTE: For primary instructor approval, state and federal regulations require that you have a minimum of two years of experience working as a registered nurse, of which at least one year must be in the provision of long term care facility services.

Name / Location – Health Care Facility	Employment Dates From: To:
Facility Type: ☐ Nursing Home ☐ HHA ☐ Hospital ☐ Hospice ☐ ICF/IID ☐ Other – *Specify:*	
Name / Location – Health Care Facility	Employment Dates From: To:
Facility Type: ☐ Nursing Home ☐ HHA ☐ Hospital ☐ Hospice ☐ ICF/IID ☐ Other – *Specify:*	
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Name / Location – Health Care Facility	Employment Dates From: To:
Facility Type: ☐ Nursing Home ☐ HHA ☐ Hospital ☐ Hospice ☐ ICF/IID ☐ Other – *Specify:*	

1. List specific job duties. (Attach separate page as needed.)

2. List and describe employment in the care of the chronically ill.

3. List and describe home health care experiences (if applicable).

DHS USE ONLY		
☐ Approved ☐ Approval Pending, Information Needed ☐ Denied – *Provide reason for denial below.*		
Name – Reviewer	Title	Date *(MM/dd/yyyy)*