

**DEPARTMENT OF HEALTH SERVICES**Division of Quality Assurance  
F-62687 (11/2019)**STATE OF WISCONSIN**Wis. Stat. § 146.40  
Wis. Admin. Code ch. DHS 129**NURSE AIDE TRAINING PROGRAM – TRAINER APPLICATION**

- The U.S. 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 program trainers 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 program trainer eligibility requirements have been met.
- Providing the program trainer's social security number is voluntary; however, social security numbers are one of the unique identifiers used to prevent incorrect identity mismatches, e.g., the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions.
- Provide requested information for all trainers. Add any information that you believe is pertinent. (Submit additional pages, if needed.)
- Submit completed application and materials to: **Wisconsin Nurse Aide Training Consultant / Office of Caregiver Quality / P.O. Box 2969 / Madison, WI 53701-2969**
- If you have questions about completing this form, call **(608) 261-8319**.
- **Print clearly in BLACK INK or type.**

**I. PERSONAL INFORMATION****Provide the following:**

- Copy of your Social Security card and a form of identification to verify your current name
- Copy of your current applicable Wisconsin license
- Copy of your resume
- Copy of the content of your presentation
- Copy of your orientation plan
- Copy of completed BID, DOJ, and DHS Responses, if you will be participating in clinicals with the students.

**Note:** To be approved as a program trainer, state and federal regulations require that you have a minimum of one year of experience in the area in which you will provide training.

Full Name (Last, First, MI) <b>(DO NOT USE NICKNAMES.)</b>	Title	Social Security No.
Name - Program		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male

**II. EDUCATION**

Name – School / College	Years Attended	Year of Graduation	
Diploma or Degree	Year Received		
Street Address	City	State	Zip Code

**III. WORK EXPERIENCE**

Name – Employer			
Street Address	City	State	Zip Code
Position Held	Start Date (MM/dd/yyyy)	End Date (MM/dd/yyyy)	

**IV. LICENSURE** (Attach additional pages, if necessary.)

Type of License (Attach copy of license.)	State of Issuance	Issuance Date (MM/dd/yyyy)	Expiration Date (MM/dd/yyyy)
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**DHS OFFICE USE ONLY**

Program Trainer Approved     Approval Pending - Information Needed     Program Trainer Denied – Provide reason below.

Name – Reviewer	Title	Date Reviewed (MM/dd/yyyy)
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