

Provider Reapplication to Administer or Discontinue Infection Control Training

New York State Department of Health
Healthcare Epidemiology and Infection Control Program

Print, Complete, and Mail or Fax to:

New York State Department of Health
Empire State Plaza, Corning Tower, Room 523
Albany, NY 12236

(518) 474-1142
(518) 402-5165 (FAX)

Approved _____
Disapproved _____
Provider # _____
Date Notified _____
Renewal Date _____

General Information

Do you intend to continue offering Infection Control Training?

- Yes (Please complete all of the reapplication, including the shaded area below, and submit to the address above)
 No (Please complete the shaded area below and submit to the address above)

Provider Name (Use facility or organization name if not an Independent Provider) _____

Provider Number _____ County _____

Type of provider (check one if applicable) Long Term Care Home Care Independent (e.g. CIC®) Hospital
 Other _____

New Name (if applicable) _____

Address _____

City _____ State _____ Zip _____ County _____

Contact Person _____ Title _____

Phone _____ Fax _____ E-mail _____

Qualifications

For all Article 28 applicants and renewal applicants such as hospitals, long term care facilities and home care, the recommended qualifications for the course work instructors are (check those that apply):

- Certification in infection control by the Certification Board of Infection Control and Epidemiology® (CBIC®), or,
 Current experience in infection control.

For all non-Article 28 applicants and renewal applicants such as organizations and consultants, the required qualifications for the course work instructors are (check those that apply):

- Current certification in infection control by CBIC®, or,
 Active in infection control practice within an institution for a minimum of 2 years, or,
 Practicing infectious disease physician.

Professions for Which You Were Previously Approved to Train (Check all that apply)

- Physicians Registered Physician Assistants Special Assistants Podiatrists Registered Nurses
 Licensed Practical Nurses Dentists Dental Hygienist Optometrists

Would You Like to Add Any New Professions to Your Target Audience at This Time? (Check all that apply):

- Yes Physicians Registered Physician Assistants Special Assistants Podiatrists Registered Nurses
 Licensed Practical Nurses Dentists Dental Hygienist Optometrists
 No

Eligible Groups (Check all that apply)

- Employees Credentialed/Affiliated Professionals Community-based Providers

Instructor Information (Person(s) responsible for teaching the course)

Name _____ Title _____

- RN LPN MD PhD MPH CIC BA BS MA MS Other _____

Phone _____ FAX _____ Email _____

Name _____ Title _____

- RN LPN MD PhD MPH CIC BA BS MA MS Other _____

Phone _____ FAX _____ Email _____

Terms of Agreement (Please check boxes)

- The provider agrees that the course work or training will cover the core elements specified in the *New York State Department of Health and New York State Education Department's Infection Control Training Syllabus* (please visit: http://www.health.state.ny.us/professionals/diseases/reporting/communicable/infection/outline_updates/docs/infection_control_syllabus.pdf to obtain a copy). The provider agrees that the course work will be tailored to meet the needs of the target audience and will be current, relevant and scientifically accurate.
- The provider agrees that the instructional staff will possess the training, experience, or earned degrees necessary to insure that the educational goals of the program are met.
- The provider agrees to issue a Certificate of Completion to training participants. The format must contain information set forth by the example included in each syllabus. The provider agrees to assume the cost of reproducing this or any other training related material. The provider further agrees to assume the cost of postage, handling, or any other cost associated with communicating with personnel of the Department of Health or complying with directives of this agency.
- The provider agrees to maintain a record of course participants for no less than six (6) years from the date of the completion of the course. These records may be subject to the review of the Department of Health and the provider agrees to make these records available to the Department or its designee(s) during regular business hours. The provider also agrees to respond to inquiries from the Department regarding these documents.
- The provider agrees that the Department of Health may review and evaluate the coursework or training offered and that termination of the provider's approved status may result if the Department determines that the course work is inadequate, incomplete, inaccurate or otherwise unsatisfactory.
- The provider understands and agrees that failure to comply with this agreement may result in termination of the provider agreement by the New York State Department of Health.

Signature of Authorized Official _____

Print or Type Name _____ Title _____

Date _____