# stop-sign-

**Please read this information before completing the application.**

**GENERAL INFORMATION:**

**Advanced Home Health Aide Training Program Entity (AHHATP) Eligibility**:

An agency/organization is eligible to submit an application for approval if the following criteria are met:

1. The organization is currently identified on the New York State Home Care Worker Registry as a training entity of one or more approved Home Health Aide Training Programs (HHATPs).
2. The organization has at least one year of experience operating one or more Home Health Aide Training Programs approved by NYSED or DOH and must have enrolled at least ten students who completed a full Home Health Aide Training Program during the past 12 months.
3. The organization is currently in full compliance with all applicable laws and regulations relating to its approved Home Health Aide Training Program(s) and other New York State approved education programs.

**Steps for Initial AHHATP Approval**

1. Submit a completed Initial AHHATP application with the appropriate DOH or NYSED office. Approvals of AHHATPs are location specific. An applicant must file a separate application for each AHHATP training site (classroom and skills lab). The application must include the applicant’s associated agency License Number or State Education Number from the New York State Home Care Worker Registry. Applications should be sent to the appropriate office by regular mail.
2. After reviewing the AHHATP application, a representative of NYSED or DOH may make scheduled or unscheduled visits to the applicant’s training site(s). NYSED or DOH may request additional information or ask additional questions. The applicant must provide complete responses within 30 days. If the applicant fails to respond fully in writing within 30 days, the application will be deemed to be abandoned and withdrawn. NYSED/DOH will have no further obligation to review the application.
3. After evaluation has been completed the reviewing agency will send an official determination letter of approval or denial for a new AHHATP. If the AHHATP is approved, NYSED or DOH staff will enter the approval on the New York State Home Care Registry. Approval to operate an AHHATP is for a three-year period.

**Denying or Rescinding Approval to Operate an AHHATP**

NYSED or DOH may deny or rescind approval to offer an AHHATP for the following reasons:

1. Submitting an incomplete initial application.
2. Fraudulent or inaccurate representation of information during the application review

 process.

1. Failure to meet training entity responsibilities and record keeping.
2. Renewal application submitted after deadline.
3. Failure to respond to requests for additional information within 30 days.
4. Failure to allow inspections of instructional facilities.
5. Applicant’s approval to operate a HHATP has been rescinded or terminated.
6. Disclosing false, inaccurate and/or misleading information or advertising relating to the

AHHATP to the public, prospective students or students.

1. Failure to meet requirements for supervised clinical practicum including requirements

relating to clinical agency affiliation agreements.

1. Failure to obtain prior written approval from NYSED or DOH to:

(a) change or add RN faculty,

(b) change the location of didactic training or skills labs,

(c) enter into new agreements or change existing agreements with clinical providers for supervised clinical practicum,

(d) change the approved curriculum,

(e) change the ownership of the training entity.

11. Failure Rate on the New York Medication Aide Certification Exam® (MACE®) of greater than 40 percent for graduates of the AHHATP who are taking the MACE®  for the first time.

12. AHHATP completion rates of less than 60% by the planned end of the program.

13. Failure to include accurate and timely information on the New York State Home Care

Worker Registry or remove outdated information in a timely fashion.

If NYSED or DOH denies approval of a new AHHATP in writing, the applicant must wait at least 90 days before submitting a new application and must pay another application review fee (if applicable).

NYSED or DOH may rescind approval to operate a AHHATP during a three-year approval period for the reasons described above. Issues raised through student complaints may result in further program monitoring or rescinding of approval. If NYSED or DOH rescinds approval to operate an AHHATP, the training entity shall not offer any new training programs or enroll any new students after the effective end date of the program. NYSED and DOH will not review an application to operate a new AHHATP for a period of 2 years after the rescind date.

A training entity’s approval to operate an AHHATP automatically terminates when the training entity’s approval to operate a HHATP at the same location terminates or when there is a change in ownership of the training entity or sponsoring agency.

**Government Agencies that Approve AHHATPs**

The New York State Department of Health (DOH) and the New York State Education Department (NYSED) approve organizations to operate AHHATPs. AHHATPs cannot be dually approved by DOH and NYSED.

AHHATPs approved by DOH are not allowed to charge tuition for training. The program may charge a student fee, up to a maximum of $100.00 to recoup the cost of items the student is required to have and which the student retains upon completion or separation from the program. The AHHATP must be able to verify an associated cost if the student fee is charged.

Any program intending to charge over $100.00 in fees or tuition must apply to NYSED for approval and should not seek DOH approval.

**For eligible training entities under the NYSDOH as a licensed home care services agency (LHCSA), certified home health agency (CHHA), or Hospice.**

NYS Department of Health

Division of Home and Community Based Services

875 Central Avenue

Albany, NY 12206

Phone: 518-408-1638 E-Mail: ahhatp@health.ny.gov

**For eligible training entities under NYSED’s Bureau of Proprietary School Supervisions:**

Bureau of Proprietary School Supervision

Education Building, EBA 560
89 Washington Avenue

Albany, NY 12234

Phone: 518-474-3969 E-Mail: bpss@nysed.gov

**For eligible training entities under NYSED’s BOCES, high schools, and adult programs:**

Career and Technical Education

Education Building, Room 315

89 Washington Avenue

Albany, NY 12234

Phone: 518-486-1547 E-Mail: emsccte@nysed.gov

**For eligible training entities under NYSED’s colleges, universities and Educational Opportunity Centers:**

Office of the Professions

Professional Education Program Review

Education Building, 2nd Floor West Wing

89 Washington Avenue

Albany, NY 12234

Phone: 518-474-3817 ext. 360 E-Mail: OPPROGS@nysed.gov

# Please do not submit an incomplete application.

**Only submit the application when all parts and sections are complete**.

# Checklist of Required Parts, Sections, Forms and Documents:

# Part 1: Information

[ ]  Section 1. General Agency information

[ ]  Section 2. Faculty and Staff

[ ]  Section 3. Curriculum Summary

**Part 2. Certifications. Submit one.**

 [ ]  DOH Operator Certification **OR**

**[ ]** NYSED Operator Certification

**Part 3. Faculty and Staff**

 For the Director/Coordinator and each Nurse Instructor:

 [ ]  Faculty & Staff Director/Coordinator and Nurse Instructor Data Sheet

 [ ]  Current resume to support education and experience

[ ]  Copy of NYS RN License and current registration or printout from the Online License Verification System available from <http://www.op.nysed.gov/opsearches.htm>

[ ]  Director/Coordinator or Nurse Instructor Attestation

**Part 4: Location and Equipment List**

**Part 5: Supervised Clinical Practicum Contracts**

[ ]  All executed contracts.

**Part 6: Agency/Program Policies and Procedures:**

**Review AHHATP Guide Document for Program Responsibilities**

[ ]  Student admission policy and procedure for evaluating English language and math skills

[ ]  Student attendance policies

[ ]  Student rights

[ ]  Testing policies and procedures

[ ]  Skills and content remedial plan

[ ]  Policy for record maintenance

[ ]  Home Care Worker Registry (HCWR) policies

[ ]  AHHATP Quality Management Program

[ ]  Policy and procedures for notifying DOH or SED of program changes

[ ]  For Department of Health approved programs: Procedure for biannual

 submission of the proposed training class schedule on April 1st and October 1st

**Part 7: Detailed AHHATP Curriculum Plan**

**APPLICATION PART I**

**Section 1. General Agency Information:**

|  |
| --- |
| **SPONSORING AGENCY NAME**  |
|  |
| STREET ADDRESS | CITY | STATE | ZIP CODE |
|       |       |       |       |
| **TRAINING PROGRAM SITE (IF DIFFERENT FROM LOCATION ABOVE) only one site per application** |
| STREET ADDRESS | CITY | STATE | ZIP CODE |
|       |       |       |       |
| County of training site:       |  |
| CHHA: [ ]  YES [ ]  NO  |  OPERATING CERTIFICATE NO.                              |
| LHCSA: [ ]  YES [ ]  NO  | LICENSE NO.                 L              |
| HOSPICE: [ ]  YES [ ]  NO  | OPERATING CERTIFICATE NO.                             F |
| PROPRIETARY SCHOOL: [ ]  YES [ ]  NO  |       |
| BOCES/ADULT HIGH SCHOOLS: [ ]  YES [ ]  NO  |       |
| COLLEGES/UNIVERSITY/EOC: [ ]  YES [ ]  NO  |       |
|  |  |
| **Year the agency was first approved to operate a HHATP:**  |
| **Number of HHATP classes offered in the last 12 months from date of application:** |
| **Start Date of last completed HHATP class offered:** |
| **End Date of last completed HHHTP class offered:**  |
|  |
| **NAME OF CONTACT PERSON** |
| [ ] Ms. [ ] Mrs. [ ] Mr. [ ] Dr.       |
| STREET ADDRESS | CITY | STATE | ZIP CODE |
|       |       |       |       |
|  |  |  |
| TELEPHONE NO. | FAX NO. | E-MAIL ADDRESS |
|       |       |       |

**Section 2: Faculty and Staff (SEE AHHATP Program Guide for DEFINITIONS)**

1. List the name of the person(s) identified as the Official Agency Designee and the person authorized to execute a legally binding instrument on behalf of the training entity (Senior Official).

|  |  |
| --- | --- |
| Official Agency Designee: |       |
| Senior Official(s): |       |

2.List the names of the Director/Coordinator and Nurse Instructors seeking approval to teach the AHHATP.

|  |  |
| --- | --- |
| Director/Coordinator:  |       |
| Nurse Instructor(s): |       |
|  |       |
|  |       |
|  |       |
|  |       |

**Section 3: Curriculum Summary**

1. Curriculum Plan/Training Program Schedule:

Please provide the following information regarding the AHHA Training Program Curriculum:

Classroom Instructional hours

Clinical Skills Laboratory Instructional hours

Supervised Clinical Practicum hours

Total AHHA Training Program hours

Total length (in days) of the program from the first day to the last day of training

Expected starting date of first AHHATP

Expected number of programs to be offered annually

Maximum student enrollment per AHHATP

The number of classrooms that will be used for instruction

Maximum student capacity for the classroom space

 The number of AHHATP skills laboratories

Maximum student capacity for the skills laboratories space

Faculty-to-student ratio for the classroom/didactic

 Faculty-to-student ratio for skills laboratory

Faculty-to-student ratio for Supervised Clinical Practicum in the home care settings

#

#  OPERATOR’S CERTIFICATION

**DEPARTMENT OF HEALTH ONLY**

**AGENCY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGENCY ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPERATING CERTIFICATE / LICENSE #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIRECTIONS:** The agency’s Operator or Director/Administrator must read and sign the following certification statement.

**CERTIFICATION STATEMENT**

Misrepresentation or falsification of any information contained in this application may be punishable by fine and/or imprisonment under New York State law and Federal law.

The AHHA training program must be completed within 90 calendar days from the first day of class. Each student has 180 days to complete the training component and take and pass the New York Medication Aide Certification Exam® (MACE®). The AHHA certificate must be issued by the training program through the Home Care Worker Registry (HCWR). Advanced Home Health Aide Training Programs must follow the HCWR requirements regarding documentation of completion of training and the issuance of certificates.

No tuition of any form will be charged to or collected from any individual participating in advanced home health aide training or receiving an advanced home health aide certificate of completion from this agency. Advanced Home Health Aide Training Programs operated by licensed or certified agencies and hospices approved by the NYSDOH are allowed to collect a student fee, up to a maximum of $100.00 (one hundred dollars) to recoup the cost of those items the students are required to have and which the student retains upon completion or separation from the program.

The Agency is responsible for delivering the approved program through the application process; including the detailed curriculum, qualified faculty and staff.

The Agency will establish a quality management system that will meet the requirements for

program monitoring.

I hereby certify that I have read the above statements and that the information furnished in this Advanced Home Health Aide Training Program Application is true and correct to the best of my knowledge.

**Operator/Administrator Signature Date**

**Print/Type Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#

#  OPERATOR’S CERTIFICATION

**NYSED DEPARTMENT ONLY**

**AGENCY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AGENCY ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIRECTIONS:** The agency’s Operator or Director/Administrator must read and sign the following certification statement.

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The Agency is responsible for delivering the approved program through the application process; including the detailed curriculum, qualified faculty and staff.

The Agency will establish a quality management system that will meet the requirements for

program monitoring.

I hereby certify that I have read the above statements and that the information furnished in this Advanced Home Health Aide Training Program Application is true and correct to the best of my knowledge.

**Operator/Administrator Signature Date**

**Print/Type Name & Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART 3: FACULTY AND STAFF**

**DIRECTOR/COORDINATOR AND NURSE INSTRUCTOR**

**DATA SHEET**

|  |  |  |
| --- | --- | --- |
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|       |       |       |
| NEW YORK STATE RN LICENSE NUMBER |       |
| TRAINING PROGRAM NAME | LICENSE NUMBER/OP CERT NUMBER |
|       |       |
| Director/Coordinator (Requires BSN) Yes       No:        |
|       |
| EXPERIENCE |
| Start with your MOST RECENT employment. Please photocopy and attach additional sheets if necessary. |
| NAME OF EMPLOYER | POSITION HELD/JOB RESPONSIBILITIES |
|       |       |
| CONTACT NUMBER |       |
| DATES OF EMPLOYMENT | FROM: | TO: |
|       |       |
| NAME OF EMPLOYER | POSITION HELD/JOB RESPONSIBILITIES |
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| CONTACT NUMBER |       |
| DATES OF EMPLOYMENT | FROM: | TO: |
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| DATES OF EMPLOYMENT | FROM: | TO: |
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|  |
| RN SIGNATURE  | DATE |
|  **X** |        |

|  |
| --- |
| FOR OFFICIAL DEPARTMENT USE ONLY |
| Approved | Date | By: Name |
|        |        |        |

**Director/Coordinator or Nurse Instructor Attestation**

Misrepresentation or falsification of any information contained in this application may be punishable by fine and/or imprisonment under New York State law and Federal law.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(print name)** do attest that the information provided on the Faculty/Staff data sheet and all additional attachment(s) is evidence of my education and experience; and is true and accurate as of the date of my signature.

I understand that:

My name and nursing license information will appear on the Home Care Worker Registry (HCWR) Database.

My name will be associated with the AHHATP where I provide instruction and will appear as such on the HCWR Database.

I cannot teach in any other training program or location unless prior approval is obtained by the Training Entity from DOH or NYSED.

I am responsible to ensure compliance with the AHHATP requirements set forth in the Advanced Home Health Aide Training Program Guide.

The training program must notify the Department of Health or State Education

Department if I leave employment for the AHHATP so that my name and authorization to teach can be removed from the HCR Database.

I understand that if I am concerned about my name remaining on the HCWR, I should contact the Department of Health Home Care Worker Registry at 1-877-877-1827 or by e-mail to hcreg@health.ny.gov.

Please sign and date:

**Nurse Instructor Signature Date**

**Director/Coordinator Signature Date**

**PART 4: LOCATION AND EQUIPMENT LIST**

 **Attach additional sheets as necessary.**

|  |
| --- |
| **1. The location address and county where the program will be offered.** |
|  |
| **2. Describe the physical space where the program will be offered.**  |
|  |
| **3. Provide a detailed equipment list for the classroom space and the skills laboratory that will be used for the delivery of instruction.**  |
|  |
| **4. Describe the process for equipment maintenance and replacement.** |
|  |

**Part 5: Supervised Clinical Practicum Contracts**

 **Provide a list of the agencies where students will complete the 45 hours of supervised clinical practicum under the direct supervision of a Nurse Instructor.**

**Attach all executed contracts.**

|  |  |
| --- | --- |
| **Agency Name:**  | **Contract Date:** |
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**Detailed AHHATP Curriculum Plan**

**Complete the curriculum plan below to demonstrate that all modules and skill competencies are provided and evaluation of student learning completed.**

* **The Advanced Home Health Aide Detailed Curriculum is required for programs leading to the AHHA certification.**
* **Please be sure to include your supervised clinical practicum requirement.**
* **These times are purely instructional and does not include breaks, lunches, or testing.**
* **Please be sure to indicate how much time will be given for breaks, lunches, or testing each day.**

Complete this chart adapting the tables to the presentation of your curriculum. This is a word document and you can edit the template by adding rows and additional tables.

**EXAMPLE**

 **Day 1 Total Time in Minutes: 390**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
| I, A | Home Care, The Home Care Worker and The ClientWhat is a Home Care WorkerProviding Home Care | 90 |  | 90 |
|  | Morning Break- 15 minutes |  |  |  |
| II, A, B, C, D, E | Theories of Basic Human NeedsDiversityCommunication and Interpersonal SkillsCaregiver Observation, Recording and ReportingConfidentiality | 4530453030 |  | 4530453030 |
|  | Lunch Break- 30 minutes  |  |  |  |
| III, A, B, C | What is agingAging and the BodyAging and the Mind | 120 |  | 120 |
| **TOTAL:** | **390** | **0** | **390** |

**TRAINING PROGRAM NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Day 1 Total Time in Minutes:**

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| --- | --- | --- | --- | --- |
| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 2 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 3 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 4 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 5 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 6 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 7 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 8 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 9 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 10 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 11 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 12 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 13 Total Time in Minutes:**

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| --- | --- | --- | --- | --- |
| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 14 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 15 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 16 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 17 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 18 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 19 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

 **Day 20 Total Time in Minutes:**

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| **Unit** | **Topic Area** | **Class Time** | **Lab Time** | **Total Time** |
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| **TOTAL:** |  |  |  |

**BELOW FOR SED/DOH USE ONLY:**

DATE OF RECEIPT OF APPLICATION: \_\_\_\_/\_\_\_\_/\_\_\_\_

REVIEWED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request for additional information/clarification \_\_\_\_/\_\_\_\_/\_\_\_\_

Date additional information received \_\_\_\_/\_\_\_\_/\_\_\_\_

Request for additional information/clarification \_\_\_\_/\_\_\_\_/\_\_\_\_

Date additional information received \_\_\_\_/\_\_\_\_/\_\_\_\_

Application Approved: Yes\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DATE OF TRAINING PROGRAM APPROVAL: \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE OF SED/DOH RESPONSE: \_\_\_\_/\_\_\_\_/\_\_\_\_