State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division

REQUEST FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM CERTIFICATION

REQUESTING ORGANIZATION OR FACILITY INFORMATION

_____ Phone: _____
Name of Organization/Facility

_____ ZIP Code: _____
Address (Street, City, State)

Name of Administrator: _____

Administrator's e-mail address: _____

IF OTHER THAN ADMINISTRATOR, CURRICULUM INFORMATION SUBMITTED BY:

Name: _____ Title: _____

I certify that the curriculum information submitted is true and correct, and that subjects are designed to meet requirements for nurse aide training as delineated in the Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1989(f).

☐ Check this box if request is for a location using existing curriculum with no changes.

Signed: _____

Date: _____

==========

(To be completed by the State)

☐ Program certification effective _____ , not to exceed _____
☐ Conditions attached.
☐ Program not certified.
☐ Deficiencies attached.

Signed: _____
DHS/SSD Representative

Date: _____