LOUISIANA DEPARTMENT OF HEALTH

NURSE AIDE TRAINING PROGRAM CHANGE FORM

*Program Name:	*Program Code: NA

Type of Change Requested-*use for requests for change to your program*

*REQUIRED—EFFECTIVE DATE OF CHANGE(S):

SEE WEBSITE FOR INSTRUCTIONS. All program changes must be submitted for approval. Changes **shall not** be implemented **prior to approval**, except in the case of addition/removal of RN Coordinators, Instructors, and Clinical Sites. The sections to be completed for each change type is provided. Changes will not be approved if required section is incomplete or additional information is not submitted. ***Indicates required field, regardless of change requested.*

	*CHANGE(S) REQUESTED:	SECTION(S) TO BE COMPLETED:
☐	Address, Phone, Fax, Owner/Administrator, Email changes	1
☐	Ownership or School Name	1
☐	Termination (closure) of training program	1
☐	Textbook or Program Policies	2
☐	Total Program Hours (class, skills, clinical)	2
☐	Class Offering Days/Times or Addition of Class Offering	2
☐	RN Coordinator, Instructor, or Clinical Site Addition or Removal	3 and/or 4
☐	Other (specify)	any related to request

Section 1: Program Demographic and Contact Information

CURRENT INFORMATION:	*REQUESTED CHANGE(S)/UPDATE(S):*
Program name:	Program name:
Physical address of classroom:	Physical address of classroom:
Mailing address of program:	Mailing address of program:
*Facility/program email:	Facility/program email:
*Name of Program owner/administrator:	Name of Program owner/administrator:
*Owner/administrator email:	Owner/administrator email:
Telephone (with area code):	Telephone (with area code):
Fax number (with area code):	Fax number (with area code):
Hours of Operation (NOT instruction times):	Hours of Operation (NOT instruction times):

Section 2: Program Information

PROGRAM HOURS (complete ALL fields, even those without changes)

Total (do not include orientation)	Classroom/theory *(min 24)* Lab/skills *(min 16)*	Orientation *(min 4)* Clinical *(min 40)*

NOTE: Changes to Classroom and Lab/skills time requires submission of LDH curriculum, LDH skills performance record, and revised policy.

INSTRUCTION DAYS/TIMES (complete ALL fields, even if no changes)

Instruction schedule	**Instruction days** *(ex. Monday thru Friday)*	**Total # of days**	**Times of Instruction** *(ex: 8AM to 4PM, 1 hour break)*	**Total Instruction Time** *(in hours; without breaks)*
Classroom/lab				
Clinical orientation				
Clinical Instruction				
Totals	n/a		n/a	*(do not include orientation)*

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(IF APPLICABLE) INSTRUCTION DAYS/TIME OF ADDITIONAL CLASS (complete ALL fields, even if no changes)				
Instruction schedule	**Instruction days** *(ex. Monday thru Friday)*	**Total # of days**	**Times of Instruction** *(ex: 8AM to 4PM, 1 hour break)*	**Total Instruction Time** *(in hours; without breaks)*
Classroom/lab				
Clinical orientation				
Clinical Instruction				
Totals	n/a		n/a	*(do not include orientation)*

(IF APPLICABLE) INSTRUCTION DAYS/TIMES OF ADDITIONAL CLASS (complete ALL fields, even if no changes)				
Instruction schedule	**Instruction days** *(ex. Monday thru Friday)*	**Total # of days**	**Times of Instruction** *(ex: 8AM to 4PM, 1 hour break)*	**Total Instruction Time** *(in hours; without breaks)*
Classroom/lab				
Clinical orientation				
Clinical Instruction				
Totals	n/a		n/a	*(do not include orientation)*

TEXTBOOK CHANGE (must use current edition)

Textbook: ☐ *Nursing Assisting: A Foundation in Caregiving,* Hartman Publishing: ed.
☐ *How to be a Nurse Assistant*, American Healthcare Association: ed.

NOTE: Changes to Classroom and Lab/skills time requires submission of LDH curriculum, LDH skills performance record, and revised policy

Section 3: Instructors *(Will not receive approval letter)*

RN Coordinator(s)-must include new and currently active

☐ Add ☐ Remove	RN Coordinator: Email:	☐ Add ☐ Remove	RN Coordinator: Email:
☐ Add ☐ Remove	RN Coordinator: Email:	☐ Add ☐ Remove	RN Coordinator: Email:

Instructor(s)-must include new and currently active

☐ Add ☐ Remove	Instructor: Email:	☐ Add ☐ Remove	Instructor: Email:
☐ Add ☐ Remove	Instructor: Email:	☐ Add ☐ Remove	Instructor: Email:
☐ Add ☐ Remove	Instructor: Email:	☐ Add ☐ Remove	Instructor: Email:

Section 4: Clinical Training Sites-ONLY NURSING HOME OR SNF *(Will not receive approval letter)*

Clinical sites-include new and currently active

Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no
Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no
Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no
Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no
Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no
Clinical site: Address:	Contract Effective Date: Contract Expiration Date:	Auto renew? ☐ yes ☐ no

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Section 5: Statement of Acknowledgement and Attestation	
Note: Any falsified documents submitted to this office will be forwarded to the Office of the Attorney General for possible prosecution.	
By virtue of my signature, I certify that all information herein is true, correct, and supportable by documentation to the best of my knowledge. I further attest that all changes reported are in compliance with all state and federal regulations, as well as any policies of the Louisiana Department of Health (LDH). It is my responsibility to notify the LDH in writing of any changes to program. I understand that failure to adhere to any state or federal regulations, or LDH policies, may result in loss of approval to conduct Nurse Aide Training in the state of LA.	
Administrator or RN Coordinator	Title

Signature of applicant *(electronic is acceptable)*	Date

EMAIL *(do not scan)* COMPLETED FORM to LA.NATP@la.gov

****NOTE****

To ensure ability to sign, email, and view required fields, ***download*** Change Form ***prior to*** editing