FOR OFFICE USE ONLY
Date Received
Receipt #
ID #
Issue Date
License #

Rhode Island Department of Health
Room 104
3 Capitol Hill
Providence, RI 02908-5097

OFFICE USE ONLY

Instructions and
License Application for

License As A
Nursing Assistant Training Program

DO NOT REMOVE THIS PAGE FROM APPLICATION

Applicant - Print Name (Full Name)

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 01/02/2019 jcp

LICENSURE REQUIREMENTS

Please review the following checklists CAREFULLY. Listed are all of the documents and fee that you will need for the application. All items must be submitted before an application is complete. Applications are valid for a 1 year period or a new application and fee must be sumbitted.

- [ ] Completed Application with Cover Page; and
- [ ] Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$325.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE; and
- [ ] Evidence of support and fiscal administration accountability; and
- [ ] Sources and locations of potential students, faculty, classrooms, conference rooms, clinical laboratory for practical experience and other resources; and
- [ ] Names and qualifications of instructors; and
- [ ] A copy of the curriculum including provisions for the practical experience; The nursing assistant training program shall consist of no less than one hundred twenty (120) clock hours including no less than forty (40) hours of practical training and
- [ ] Written statements of purpose, philosophy and objectives of the program; and
- [ ] Organization with clearly defined authorities and responsibilities and a chart showing the relationships and channels of communication of the program to other agencies; and
- [ ] Practical experiences related to areas of instruction of the didactic segment of the program; and
- [ ] Written policies and procedures pertaining to the nursing assistant training program

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

It is the responsiblity of the applicant to ensure all requirements are met pursuant to the Rhode Island Rules and Regulations 216-RICR-40-05-22.

State of Rhode Island

Application for Nursing Assistant Training Program

Type or block print only. Do not use felt-tip pens.

1. Name

Please provide the name of the facility (as known to the public for which you are applying for this license.

Facility Name

2. Facility Contact Person:

Please provide the name and phone number of the contact person for this facility

First Name

Last Name

Contact Phone

Contact Fax Number

3. Facility Mailing Information

It is your responsibility to notify the board of all address changes.

1st Line Address (Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Phone

Extension

Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

4. Facility Location Address

It is your responsibility to notify the board of all address changes.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

State

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone

Extension

Business Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

5. Type of Ownership

- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Partner
- ☐ Sole Proprietorship
- ☐ Limited Partnership
- ☐ Partnership
- ☐ Governmental Entity
- ☐ Other (Describe):

6. Ownership Information:

Provide the name address and telephone number(s) of the facility/business owner in the spaces provided.

Name of Owner

D.B.A. (Doing Business As)

First Line Address

Second Line Address

Third Line Address

City

State/Province

Zip Code

Country, If NOT U.S.

Postal Code, If NOT U.S.

Facility Phone

Extension

Facility Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

U.S. Social Security Number (SSN)

Federal Employer Identification Number (FEIN)

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN)//Federal Employer Identification Number (FEIN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

NOTE: If you are the sole proprietor of a facility or business, then you must supply your Social Security Number (SSN). If you are an individual representing a facility or a business that is seeking licensure, then you must supply the Federal Employer Identification Number (FEIN) for the facility or the business.

7. Nursing Facility/ Hospital:

State licensure regulations require that your clinical training program be affiliated with a nursing facility or hospital. Please provide the name and RI License Number of the Nursing Facility or Hospital

Facility/Hospital Name

RI License Number

8. Program Coordinator:

Please provide the information for the program coordinator.

NOTE: Program Coordinators must be licensed RN's with at least 2 years of nursing experience and one year of experience in the provision of long term care services.

First Name

Last Name

Contact Phone

Contact Fax Number

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

RI RN License Number

Please provide a copy of your current resume.

9. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this license to practice in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Division of Taxation.

_____ _____

Signature of Authorized Person Date of Signature (MM/DD/YY)