**C.N.A. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   QMA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     HYBRID \_\_\_\_\_\_\_\_\_\_\_\_**

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| Program Sponsor: |  |
| Facility/Program Number: |  |
| AddressCity, State, Zip |  |
| Phone Number: |  |
| Fax Number: |  |
| Email Address: |  |
| Program Director: |  |
| Program Instructor(s): |  |
| **Classroom** Site and Address: |  |
| Classroom Dates | Start Date:   End Date:  |
| Classroom Times | Start Time: End Time:  |
| Classroom Days per Week | Days per week:                   M\_\_\_ T\_\_\_ W\_\_\_ Th\_\_\_ F\_\_\_ Sat\_\_\_   Sun\_\_\_  |
| **Clinical** Site and Address: |  |
| Clinical Dates | Start Date:   End Date:  |
| Clinical Times | Start Time:                           End Time:  |
| Clinical Days per Week | Days per week:                  M\_\_\_ T\_\_\_ W\_\_\_ Th\_\_\_ F\_\_\_ Sat\_\_\_   Sun\_\_\_  |
| Clinical Supervisor(s): |  |
| Clinical Instructor(s): |  |
| Total Proposed Hours: |  |
| Textbook(s): |  |
| Number of Students |  |
| Dates Class/Clinical Will Not Be in Session: |  |
| Guidelines: | * Approved programs are requested to copy this form for future use.  All approved programs must submit program schedule information, on this form only**, AT LEAST** 10 days prior to class start date.
* Once this form has been completed either fax, email or mail to ISDH:

Indiana State Department of HealthSurvey Support & Guidance2 N. Meridian St, 4BIndianapolis, IN  46204FAX:  (317)233-7322ISDHLTCTrainingprograms@isdh.in.gov * Any time there are changes (clinical/classroom site or program director/delegated instructor) made to your program, this office MUST be notified and approval granted before the change is made.  Failure to notify this office will nullify your program and any and all students that are affected by the change will need to be retrained.
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