



Board of Nursing

Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

Maryland Board of Nursing

Nursing Assistant Training Program/Acute Care Nursing Assistant Training Program Clinical Facility Profile Form

Thank you for taking the time to complete the following Clinical Facility Profile Form. This form is being collected to enable the Board to assess compliance with the Code of Maryland Regulations (COMAR) and Code of Federal Regulations (CFR), more specifically, *COMAR 10.39.02.05D Facilities and Resources* and *42 CFR 483.151(b) Requirements for Approval of Programs*.

The Clinical Facility Profile Form must be submitted with the following requests:

- Application for Initial approval
- Application for Renewal of Approval
- Addition of Clinical Facilities via the Substantial Program Change Request Form

The following accompanying documentation must be submitted with this form:

- Signed written agreement
- Statement of approval (e.g., copy of license from the Office of Health Care Quality (OHCQ) or accreditation letter from the Joint Commission)
- If applicable, evidence of waiver of disapproval or civil money penalty reduction from OHCQ and/or the Centers for Medicare & Medicaid Services (CMS).

Note: *The addition of any new clinical facilities must be approved by the Maryland Board of Nursing prior to being used by the training program for student learning experiences.*

Return the completed form and supporting documentation to the Certifications Training Programs Unit at: mbon.cnatrainingprogram@maryland.gov. Review the form for accuracy and completeness prior to submission. Forms that are incomplete or require corrections will be returned to the training program for revision.

4140 Patterson Avenue - Baltimore, Maryland 21215-2254
Toll Free: 1 (888) 202 – 9861 • Phone: (410) 585 – 1900 • TTY/TDD: 1 (800) 735 – 2258
www.health.maryland.gov/mbon

Interpreter Services are available upon request.

Clinical Facility Profile Form

PROGRAM INFORMATION		
Program Name:		Program Code:
Address		
Street:		
City	State	Zip
Website:		
Email:	Phone:	

INFORMATION ABOUT THE CLINICAL FACILITY		
Type of Clinical Facility:		
<input type="checkbox"/> Assisted Living Program <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Other		
Name of Clinical Facility:		
Facility Address		
Street:		
City:	State:	Zip:
Phone:		Fax
Contact Information		
Name of Administrator:		
Administrator Email:		Administrator Phone:
If applicable, date of the most recent review of the written agreement: <i>See COMAR 10.39.02.05D(6)(b)(ii).</i>		
Description of Facility		
Number of Beds:		Occupancy Rate:
Description of Client Population		
Primary Diagnosis:		Average Age:
Average Length of Stay:	Types of Specialty Units (if any):	
Staffing		
Number of Full-Time Staff		
RNs:	LPNs:	Medicine Aides:
CNA-I(s):		CNA-II(s):
Number of Part-Time Staff		

Clinical Facility Profile Form

RNs:	LPNs:	Medicine Aides:	CNA-I(s):	CNA-II(s):
42 CFR 483.151(b)(2)(3)				
Check "Yes," "No," or "N/A" if any of the following existed in the previous two years (<i>applies to clinical rotations that will be held in a skilled nursing facility or nursing facility</i>).				
Yes	No	N/A		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skilled Nursing Facility: Operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Social Security Act.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing Facility: Operated under a waiver under section 1919(b)(4)(C)(ii) of the Social Security Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Social Security Act for a period in excess of 48 hours per week.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Social Security Act.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Social Security Act of not less than \$5,000 as adjusted annually under 45 CFR part 102.	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been subject to a remedy described in sections 1819(h)(2)(B)(i) or (iii), 1819(h)(4)1919(h)(1)(B)(i), or 1919(h)(2)(A)(i), (iii) or (iv) of the Social Security Act (including denial of payment, appointment of temporary management, termination of participation, and closure of the facility to transfer residents to another facility)?	

If applicable, provide an explanation in the space below.

SIGNATURE

I hereby certify that the information provided on and attached to this form is true and correct to the best of my knowledge.

Name of Program Coordinator:	
Signature:	Date: