Instructions For Completing
The Maryland Board of Nursing
Program Change Form: Change in Clinical Site Form

Please assure that the attached *Program Change Form: Change in Clinical Site Form* is completed correctly and in a thorough manner. For approval of the clinical site change requested, the form MUST be completed in its entirety and the required supporting documents returned with the form. Please call the Office of CNA Training Programs, at 410-585-1913 if you have questions and/or need further assistance. Thank you!

Please type or print all entries unless a signature is requested. Information must be provided in the order requested.

1. General Information

1a-1e: Please provide the name of the training program provider, the address, contact person regarding the program, telephone, and fax numbers.

2. Program Information:

2a. Please provide the date this CNA Training Program was approved by the Maryland Board of Nursing.

2b. Please provide the Program Code.

2c. Please provide the name of the Training Program Director/Coordinator.

2d. Please provide the name of the former Clinical Site and the contact person/telephone number at that Site.

Addendum 1: Attach a brief explanation regarding the affiliation termination.

2e. Please provide the name and signature of person completing this form (2f).

2g-2h: Please provide the telephone number of the person completing this form and provide the date form was completed.

3a. Please provide the name and address of the new clinical site seeking Board approval.

3b. Please provide the name of the clinical site contact person and his/her telephone number.

3c. Please indicate whether or not the new clinical site is approved by the appropriate government authority. **The clinical site must be a currently approved state facility (COMAR 10.39.06, C, AFacilities used for clinical learning experiences shall be approved by the appropriate governmental authorities. Facilities with conditional or provisional approval status may not be used for student learning experiences.@)**

Addendum 2: Attach statement of current approval and/or copy of DHMH licensure. This statement must be included with this form in order for approval request to be considered.

3d. Indicate by checking AY@ (yes) or AN@ (no) to the following statements regarding this clinical

facility: **(All statements must be answered AYes@ to receive approval.)**

>Has a sufficient number/variety of clients to provide training experience.
>Has a sufficient number of RNs/other nursing personnel to ensure safe and continuous care of clients.
>Conforms with accepted standards of nursing care/practice.
>Has a minimum of one instructor for each eight students in the clinical area.
>Has a *Written Agreement* with the Training Program.

Addenda 4-8: Attach the following documents in support of 3d above. All documents MUST be submitted in order for approval request to be considered:

>4. Description of number/variety of clients. This description should contain an overall description of the facility: number of beds, number of clients, types of clients, etc., which assure a meaningful learning experience.

>5. Number of RNs/other nursing personnel. This description should give indication of sufficient staffing; staffing ratios may be submitted.

>Description of standards of nursing care/practice utilized. This description should describe nursing care standards available on each unit; i.e., policy, procedure, protocol manuals; available reference texts, etc.

>*Written Agreement* between Training Program and Clinical Site. This is the contract between the clinical facility and Training Program. It must contain the requirements from COMAR 10.39.06.5,b:

- Be developed jointly with the clinical facility;
- Be reviewed periodically;
- Include provision for adequate notice of termination;
- Specify the responsibility of the training program to the facility and the responsibility of the facility to the training program; and
- Identify the functions and responsibilities of the parties involved.

L Please Note: All required documentation must be submitted as requested in order for the change of Clinical Site request to be considered. Please call the Office of Nursing Assistant Training Programs at 410-585-1913, if you have questions and/or need further clarification. Thank you!

Maryland Board of Nursing
Nursing Assistant Training Program
Program Change Form: Change In Clinical Site Form

I. General Information: (Please type or print all entries:)

_____

1a. Name of Program Provider/Organization

_____

1b. Address

_____ _____ _____

1c. Contact **1d. Telephone** **1e. Fax Number**

2. Program Information

2a. Program Approval (by *Maryland Board of Nursing*) Date: _____

2b. Program Code: _____

2c. Name of Training Program Director/Coordinator: _____

2d. Name/Address of Former Clinical Site: _____

_____

_____

_____ / _____
Site Contact Person/Telephone

Addendum 1: For Clinical Site Terminations, Attach explanation of affiliation termination.

_____ _____
2e. Name of Person Completing This Form 2f. Signature of Person Completing This Form

_____ _____
2g. Telephone Number 2h. Date

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3. New Clinical Site Information

3a. Name/Address of New Clinical Site: _____

_____

_____

3b. _____/ _____
Name of Clinical Site Contact Person Telephone

3c. This Clinical Facility is approved by the appropriate government authority: Y **9** N **9**

Addendum 2: Attach statement of current approval and/or copy of DHMH licensure.

3d. This Clinical Facility:

Has a sufficient number/variety of clients to provide training experience: Y **9** N **9**

Has a sufficient number of RNs/other Nursing personnel to ensure safe and continuous care of clients: Y **9** N **9**

Conforms with accepted standards of nursing care/practice: Y **9** N **9**

Has a minimum of one instructor for each eight students in the clinical area: Y **9** N **9**

Has a *Written Agreement* with the Training Program: Y **9** N **9**

Addenda 4- 8: Attach the following supporting documents:

3 **4. Description of number/variety of clients.**
3 **5. Number of RNs/other Nursing personnel.**
3 **6. Description of standards of nursing care/practice utilized.**
3 **7. Statement Re Faculty/Student Ratio**
3 **8. Written Agreement Between Training Program & Clinical Site**

For Maryland Board of Nursing Use Only

Approved: _____Yes _____No
(This approval is for this Clinical Site only)

By: _____

Date: _____

Date of Approval/Non-Approval Notification: _____
(Attach Letter)