

## LICENSEE'S REQUEST FOR COURSE APPROVAL

- Instructions:**
1. Please complete a course approval application for **each** course you are requesting to receive NHAP credit.
  2. Please enclose a **check or money order** (payable to NHAP) with the appropriate fee for **each** course you are requesting to receive NHAP credit. For a current **Fee List**, please visit our website at: [www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx](http://www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx)

ADMINISTRATOR'S NAME (Last)		(First)	
ADDRESS (Number and Street)	(City)	(State)	(Zip Code)
TELEPHONE NUMBER (Home)	E-MAIL ADDRESS		LICENSE NUMBER

### CONTINUING EDUCATION COURSE INFORMATION

PROVIDER'S NAME	PROVIDER NUMBER	TELEPHONE NUMBER	
ADDRESS OF RECORD (Number and Street Name)	(City)	(State)	(Zip Code)
TITLE OF COURSE	PROVIDER E-MAIL ADDRESS		
DATE(S) OFFERED	TOTAL CLASS HOURS	UNITS (Semester/Quarter)	
TYPE OF OFFERING (Semester, Lecture, Workshop, etc.) <input type="checkbox"/> SEMINAR <input type="checkbox"/> WORKSHOP <input type="checkbox"/> LECTURE <input type="checkbox"/> OTHER (Describe): _____	LECTURE/COURSE CONTENT		
"P" CREDIT TOPICS and HOURS REQEUSTED <input type="checkbox"/> Resident Care <input type="checkbox"/> Environment Management <input type="checkbox"/> Patient Care and Aging <input type="checkbox"/> Personnel Management <input type="checkbox"/> Regulatory Management <input type="checkbox"/> Administration, Leadership, and Management <input type="checkbox"/> Financial Management <input type="checkbox"/> Organizational Management <input type="checkbox"/> Other: _____			
VARIABLE HOURS (Min./Max Hours a Participant can Receive) _____ MINIMUM                      _____ MAXIMUM	<input type="checkbox"/> 1 DAY <input type="checkbox"/> 2 DAYS <input type="checkbox"/> 3 DAYS <input type="checkbox"/> 4 DAYS <input type="checkbox"/> 5 DAYS (OR MORE)		
PREREQUISITES			
INSTRUCTOR'S NAME			FEES
INSTRUCTOR EDUCATION			
INSTRUCTOR TEACHING EXPERIENCE			
INSTRUCTOR EXPERIENCE IN LONG-TERM CARE			
BRIEF DESCRIPTION OF COURSE (1-3) BULLETS			

COURSE OBJECTIVES (1-3 MAIN BULLETS)
TEACHING METHODS
COURSE CONTENT: (OUTLINE FORM INCLUDING HOUR-BY-HOUR AGENDA)
METHOD OF COURSE EVALUATION BY STUDENTS

**\*\*YOU MUST SUBMIT A COPY OF A CERTIFICATE OF COMPLETION OR A TRANSCRIPT WITH THIS COURSE REQUEST. THE CERTIFICATE OR TRANSCRIPT AND THE APPROVED COPY OF THIS FORM SHOULD BE RETAINED IN YOUR FILES FOR AUDIT PURPOSES. THIS APPLICATION IS NOT PROOF THAT YOU HAVE COMPLETED THIS COURSE. ONLY A CERTIFICATE OF ATTENDANCE OR A TRANSCRIPT CAN BE ACCEPTED AS PROOF OF COMPLETION.**

APPLICANT'S SIGNATURE:	DATE:
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*Maintenance of the information requested on this form is authorized by Section 1416.50 of the Health and Safety Code. No items of information are voluntary; all are required. Failure to provide any of the required information or to submit thirty (30) days prior to course date will result in the application being rejected as incomplete.*

**APPLICANTS—DO NOT USE THIS SPACE BELOW—FOR NHAP USE ONLY**

Your request for course approval has been reviewed, and the following decision has been made:

- The course is approved for full credit.
- The course is approved as an "Approved Course in Aging or Patient Care."
- The course is approved for half credit because it is in an allied field.
- NHAP credit is denied. See enclosed letter.

NHAP COURSE NUMBER	COURSE HOURS APPROVED	APPROVED BY	HOURS APPROVED
COURSE APPROVAL EXPIRATION DATE	DENIED BY		DATE

CASH # _____	STATUS <input type="checkbox"/> Approved <input type="checkbox"/> Rejected <input type="checkbox"/> Less than 30 days <input type="checkbox"/> Missing Information
NHAP INITIALS _____	<input type="checkbox"/> Resume(s) if applicable <input type="checkbox"/> Agenda
AMOUNT _____	<input type="checkbox"/> Fee for each course <input type="checkbox"/> Number of courses offered
	STAFF _____      DATE PROCESSED _____

All information requested by the application is required by the California Department of Public Health, Nursing Home Administrator Program (NHAP). Maintenance of the information requested on this form is authorized by Section 1416.50 of the Health and Safety Code. Failure to provide any of the required information will result in the application being rejected as incomplete. For more information or access to records containing your personal information maintained by CDPH, contact the NHAP, MS 3302, P.O. Box 997416, Sacramento, CA 95899-7416, (916) 552-8780.