DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Community Instructor Application

TODAY'S DATE

Use this form to apply to become a DSHS approved Community Instructor for long-term care workers for the following courses:

- Core Basic Training
- Nurse Delegation Core
- Nurse Delegation Diabetes
- Dementia Specialty Training
- Mental Health Specialty Training
- Expanded Specialty Training (Traumatic Brain Injury Specialty, Diabetes Specialty, Substance Use Disorder Specialty, and Dementia, Level 2 Specialty)

To request approval to teach Orientation, Safety Training, and Continuing Education, use Community Instructor Training Program Application and Updates, 15-551. All other DSHS course approval request forms can be downloaded on the Training Program and Instructor Application Forms page.

Submit this form with the Community Instructor Training Program Application and Updates, 15-551. Email your questions and submit your application to TrainingApprovalTPC@dshs.wa.gov.

Section 1. Instructor, Training Program Information and Courses Requested

INSTRUCTOR'S NAME

DATE OF BIRTH

INSTRUCTOR'S CONTACT INFORMATION

PHONE NUMBER (AREA CODE) ( )

CELL NUMBER (AREA CODE) ( )

EMAIL ADDRESS

NAME OF BUSINESS

If this is a new training program, please leave the Training Program Name and Number blank.

TRAINING PROGRAM NAME

TRAINING PROGRAM NUMBER

Select the courses you plan to teach and complete Appendix A:

☐ Core Basic Training ☐ Nurse Delegation Diabetes ☐ Nurse Delegation Core

Select the Specialty Training you plan to teach and complete Appendix B:

☐ Dementia Specialty Training ☐ Mental Health Specialty Training ☐ Traumatic Brain Injury Specialty Training
☐ Diabetes Specialty Training ☐ Substance Use Disorder Specialty Training
☐ Dementia, Level 2 Specialty Training (Dementia Specialty Training approval is a prerequisite)

Section 2. General Community Instructor Qualifications WAC 388-112A-1240

1. Are you 21 years old or older? ☐ Yes ☐ No
2. Are you an owner or administrator of an adult family home, assisted living facility, enhanced services facility, nursing home, home care agency, or supported living in Washington? ☐ Yes ☐ No

   If **yes**, please list the type of license and the license number. Supported living providers list the type of certification and certification number. If **no**, leave blank.

   Type of license or certification _____

   License or certification number _____
3. Are you a health care or social service professional, such as an RN, LPN, HCA, NAC, EMT, or other DOH credential? ☐ Yes ☐ No

   If **yes**, list any licenses or certifications you hold in Washington. If **no**, leave blank.

   Type of license or certification _____

   License or certification number _____
4. Have you ever had a professional health care, adult family home, assisted living or social services license or certification revoked in Washington State? ☐ Yes ☐ No

   License or certification number _____ Date of revocation _____

5. Highest level of education: ☐ High School or equivalent ☐ Associate's ☐ Bachelor's ☐ Master's ☐ PhD

6. A certificate of completion for the DSHS Adult Education class is required to teach Core Basic Training, Dementia Specialty Training, Mental Health Specialty Training, and Expanded Specialty Training. Have you attached your Adult Education certificate to this application if required?

☐ Yes ☐ No

Appendix A. Complete this section to teach Long-Term Care Worker Basic Training, Nurse Delegation Core and Nurse Delegation Diabetes [WAC 388-112A-1240]

A.1. Work Experience

List the **one-year** of work experience you have had in the last five years in an adult family home, assisted living facility, enhanced services facility, supported living, or in-home care setting.

Employer 1	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) ( )
DATES IN THIS POSITION From To	HOURS PER WEEK	SUPERVISOR'S NAME
Employer 2	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) ( )
DATES IN THIS POSITION From To	HOURS PER WEEK	SUPERVISOR'S NAME

A.2. Teaching Experience

List **100 hours** of experience teaching adults in an appropriate setting on topics directly related to basic training or basic training topics that may be offered as continuing education. If you do not meet this requirement, see WAC 388-112A-1240(4) for alternative teaching requirements. If you will administer tests, do you have experience or training in assessment and competency testing? ☐ Yes ☐ No

Employer 1	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) ( )
DATES IN THIS POSITION From To		SUPERVISOR'S NAME

If you were mentored by an approved instructor during your teaching experience, list the approved instructor's name:

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS **X**	NO. OF TIMES CLASS TAUGHT	**=** TOTAL CLASS HOURS

Employer 2	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) ( )

DATES IN THIS POSITION From To	SUPERVISOR'S NAME

If you were mentored by an approved instructor during your teaching experience, list the approved instructor's name:

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS **X**	NO. OF TIMES CLASS TAUGHT	**=** TOTAL CLASS HOURS

Appendix B. Complete this section to teach Dementia Specialty Training WAC 388-112A-1285, Mental Health Specialty Training WAC 388-112A-1270, and/or Expanded Specialties - Traumatic Brain Injury Specialty, Diabetes Specialty, Substance Use Disorder Specialty, and Dementia, Level 2 Specialty. WAC 388-112A-1292

B.1. Work Experience

List the **two-years of** full-time equivalent work experience **with** the specialty populations in this section.

Employer 1	EMPLOYER	YOUR TITLE

Type of care setting: ☐ AFH ☐ ALF ☐ ESF ☐ In-home ☐ Supported living ☐ Other

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE NUMBER (AREA CODE) ( )

DATES IN THIS POSITION From To	HOURS PER WEEK	SUPERVISOR'S NAME

Under this employer, I had specific experience in the following:

☐ Dementia ☐ Mental Health ☐ Traumatic Brain Injury ☐ Diabetes ☐ Substance Use Disorder

Employer 2	EMPLOYER	YOUR TITLE

Type of care setting: ☐ AFH ☐ ALF ☐ ESF ☐ In-home ☐ Supported living ☐ Other

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE NUMBER (AREA CODE) ( )

DATES IN THIS POSITION From To	HOURS PER WEEK	SUPERVISOR'S NAME

Under this employer, I had specific experience in the following:

☐ Dementia ☐ Mental Health ☐ Traumatic Brain Injury ☐ Diabetes ☐ Substance Use Disorder

B.2. Teaching Experience

List **200 hours** of experience teaching long-term care related subjects. If you documented this requirement in Appendix A, you may leave this section blank.

Do you have experience or training in assessment and competency testing? ☐ Yes ☐ No

Employer 1	EMPLOYER	YOUR TITLE

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE NUMBER (AREA CODE) ( )

DATES IN THIS POSITION From To	SUPERVISOR'S NAME

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS **X**	NO. OF TIMES CLASS TAUGHT	**=** TOTAL CLASS HOURS

Employer 2	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) **( )**
DATES IN THIS POSITION From To	SUPERVISOR'S NAME	

If you were mentored by an approved instructor during your teaching experience, list the approved instructor's name:

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS **X**	NO. OF TIMES CLASS TAUGHT	**=** TOTAL CLASS HOURS

B.3. Education

Does your work experience listed in B.1. total five or more years? If it does not, you must meet **BOTH**:

The **degree/credential** requirement: BA, BS, RN, or a mental health professional (as documented in Section 2 of this application);

AND

The **education** requirement on topics directly related to dementia, mental health, traumatic brain injury, diabetes, and/or substance use disorder: one year of education in college classes **or** 80 hours of seminars, conferences, and continuing education.

If you do not meet both of the requirements listed above, you **may** use your **five years of full-time equivalent work experience** with people who have mental health, dementia, and/or expanded special topic diagnoses to substitute for either the degree requirement **or** the education requirements listed above:

If you plan to use work experience, which requirement will you substitute?

Check one box only:

☐ **Degree** **OR** ☐ **One year of education**

IMPORTANT: Attach documentation that confirms your degree, licensure, and/or education (such as transcripts, diplomas, CE certificates, etc.).

NAME OF EDUCATION COURSE, CONFERENCE, OR EVENT	MONTH AND YEAR ATTENDED	HOURS / CREDITS	FOR EACH AREA OF STUDY, BRIEFLY DESCRIBE HOW RELATES TO THE TOPIC(S) OF MENTAL HEALTH, DEMENTIA, TRAUMATIC BRAIN INJURY, DIABETES AND/OR SUBSTANCE USE DISORDER

Section 3. Attestation of Accuracy

Read and complete the following attestation.

I certify and understand that:

- The information I have provided to the department in this application and during the application process is subject to investigation and verification.
- The department may obtain additional information, verification, and/or documentation related to my answers or information.
- The information provided in this application and in all additional documents is true, complete, and accurate.
- Providing false or inaccurate information are cause for rejection of this application.

SIGNATURE	DATE	JOB TITLE

Section 4. Is your application complete?

Did you remember to:

☐ Attach copies of your Specialty Training and/or Adult Education certificates of completion, if required

☐ Attach Contractor Intake form (DSHS 27-043) with copy of business license (new applicants only)

☐ Complete Section 3: Attestation of Accuracy

Email your questions and submit your application with supporting documentation (if required) to TrainingApprovalTPC@dshs.wa.gov.

For more information about long-term care worker training, please visit the DSHS Training Requirements and Classes page.