NOTICE OF SUBSTANTIAL CHANGE
NURSE AIDE TRAINING PROGRAM

- The purpose of this form is to provide the Division of Quality Assurance (DQA) with information regarding a substantial change in an approved nurse aide training program. Any substantial change must be reported to DQA in writing 10 days prior to the implementation of the change. The substantial change must not be implemented until the change is approved by DQA. DQA responds to all Notice of Substantial Change forms in writing.
- "Substantial change" is defined as any change in the program designee, primary instructor, program trainer, curriculum, classroom location, or clinical site.
- Failure to provide this information may result in the suspension or revocation of the program's certification or the imposition of a plan of correction on the program, per HFS 129, Wis. Admin. Code.
- If you have questions about the completion of this form, please contact the Office of Caregiver Quality at **(608) 261-8328**.
- Submit this completed form to: **Wisconsin Nurse Aide Training Consultant**
  Office of Caregiver Quality
  P.O. Box 2969
  Madison, WI 53701-2969

  FAX: (608) 264-6340
- **Print neatly in BLACK INK or type.**

Name - Program	Program Approval Number

CHANGE

• **Program designee changed?** *If "yes," indicate date of change and attach details, including name, telephone number, and e-mail address.*	Date (mm/dd/ccyy)
• **Primary instructor changed?** *If "yes," indicate date of change and attach details, including, name, copy of current RN license, resume, Social Security Number, home address, telephone number.*	Date (mm/dd/ccyy)
• **Program trainer changed?** *If "yes," indicate date of change and attach details.*	Date (mm/dd/ccyy)
• **Program site (instructional or clinical) changed?** *If "yes," indicate date of change and attach details, including physical and mailing address, telephone number, and FAX number.*	Date (mm/dd/ccyy)
• **Training curriculum changed?** *If "yes," indicate date of change and attach details of curriculum change.*	Date (mm/dd/ccyy)

REASON FOR CHANGE *(Identify page and section from attached application.)*

PROGRAM REPRESENTATIVE

Name – Program Representative	Title	Telephone Number	FAX Number

SIGNATURE – Program Representative	Date Signed

DHS USE ONLY

☐ Approved ☐ Entered Database Date: _____

☐ Approval Pending - Information Needed

☐ Denied Reason for Denial: _____

Name – Reviewer	Title	Date Reviewed