

EMPLOYMENT INFORMATION (Licensed Nursing Experience)

Please provide only the employment information on the following pages that directly demonstrates that you meet the instructor qualifications previously described. If additional space is needed, please follow the same format as this form. A resume may not be substituted for the information requested in this section.

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _____ To: _____ mm / dd / yr mm / dd / yr		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they performed:

Number of aides _____ Type of Work _____ Dispensed Medication _____
Employment Verification Attached _____

Employer's Name	TO EQUAL 100%	DESCRIPTION OF JOB DUTIES
Employer's Address		
Kind of Business		
Your Job Title		
From: _____ To: _____ mm / dd / yr mm / dd / yr		
Hours Per Week		

If you supervised employees, please indicate the number and type of work they performed:

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From: _____ To: _____ mm / dd / yr mm / dd / yr		
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If you supervised employees, please indicate the number and type of work they performed:

Number of aides _____ Type of Work _____ Dispensed Medication _____
Employment Verification Attached _____

ADULT EDUCATION TRAINING COURSE

Training School Name	Training Course in Adult Education or a Professional Continuing Education Course on Supervision or Adult Education may be documented by submission of a post-secondary transcript or certificate of completion.
School Mailing Address	
Dates of Attendance From: _____ To: _____ mm/dd/yy mm/dd/yy	

APPLICANT SIGNATURE: I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments. I do hereby acknowledge that it is my responsibility to obtain employment verification from current/previous employer(s) for each reference listed on the application. I am fully aware that failure to provide this information to Health Occupations Credentialing will delay the processing of this application.

Signature _____ Date _____

Please complete all employment information which demonstrates meeting instructor qualifications and attach the employment verification forms which have been completed by each employer then return to:

Health Occupations Credentialing
 Kansas Department for Aging and Disability Services
 612 S Kansas Ave
 Topeka, KS 66603

<i>KDADS OFFICE USE ONLY</i>			
Instructor ID # _____	CNA	Approval Date _____	Disapproval Date _____
Reviewer Signature _____	CMA	Approval Date _____	Disapproval Date _____
	HHA	Approval Date _____	Disapproval Date _____

HEALTH OCCUPATIONS CREDENTIALING
612 S Kansas Ave, Topeka, KS 66603

CNA-CMA-HHA INSTRUCTOR EMPLOYMENT VERIFICATION

APPLICANT: COMPLETE THIS SECTION

(Photocopy as needed and send to each employer listed on your application.)

Social Security Number _____ - _____ - _____ RN License Number ____/_____/____

Name _____
(Last) (First) (M.I.)

Other Names Used _____

Address _____
(Street) (City/State) (Zip)

Phone Number (Home) _____ (Work) _____

By my signature, I authorize the release of employment verification from the facility named below to the Kansas Department for Aging and Disability Services.

Signature _____ Date _____

EMPLOYER: COMPLETE THIS SECTION (not to be completed by applicant)

Name of Facility _____ Telephone number (____) _____

Address _____

Type of facility: Adult Care Home _____ Hospital _____ Home Health Agency _____ Other (Explain) _____

Comments:

I certify that the individual named above is/was employed by me as an LPN or RN (Circle one)

from _____ to _____.

This individual was employed as a licensed nurse as follows (number of hours per week must be included):

In an Adult Care Home or Distinct-Part Long Term Care Unit from dates: _____ to _____ Hours per week: _____

In Home Health Care services from dates: _____ to _____ Hours per week: _____

Other licensed nursing experience from dates: _____ to _____ Hours per week: _____

Experience in administering medication _____ Yes _____ No

Please explain if other licensure setting _____

Signature _____ Date _____

Title _____