TRAINING VERIFICATION FORM

Oklahoma State Department of Health
Nurse Aide Registry
PO Box 268816
Oklahoma City, OK 73126-8816
Ph. 405-426-8150

TRAINEE INFORMATION

Trainee Name: _____ Social Security #: _____-___-_____

TRAINING INFORMATION

Please check (√) the training program the trainee completed and indicate the number of training hours completed.

☐_____ Long Term Care
Hours (75) Hr. Minimum

☐_____Deeming ____ to_____
Hours 16 Hr. Minimum)

☐_____ Adult Day Care
Hours (45 Hr. Minimum)

☐_____ Home Health Aide
Hours (75 Hr. Minimum)

☐_____IDF/IID Care
Hours (75 Hr. Minimum)

☐_____ Residential Care
Hours (45 Hr. Minimum)

Date Examinee completed the training program: _____ Training Facility Code: _____

Training Program/Facility Name: _____

Training Program/Facility Address: _____

_____ _____
Instructor's Name (Please print clearly) Instructor's Signature

TRAINING VERIFICATION STATEMENT

I verify that the above named trainee has successfully completed the minimum number of training hours and all required performance checklists for program indicated above. Furthermore, this training was provided through a program approved by the Oklahoma State Department of Health within the last 24 months. (NOTE for Long-Term Care Aide and Home Care Aide Training Programs: This form must be signed by the R.N. who is listed on the NATCEP application as the R.N. Training Supervisor. LPNs cannot be Training Supervisors for LTC and HHC training programs and may not sign this form.

_____ _____
Training Supervisor's Name (Please print clearly) Training Supervisor's Signature

Area Code ( ) _____ _____
Training Supervisor's Telephone Number Date

CLINICAL EXAMINATION RECORD

The assigned RN/CSO must sign and date this form after completing the clinical skills exam. **Trainees that do not pass the clinical examinations after three attempts must retrain and repeat the testing process.**

Exam 1: RN/CSO _____ _____ _____ ☐ Pass ☐ Fail
CSO # Coordinator Signature Date

Exam 1: RN/CSO _____ _____ _____ ☐ Pass ☐ Fail
CSO # Coordinator Signature Date

Exam 1: RN/CSO _____ _____ _____ ☐ Pass ☐ Fail
CSO # Coordinator Signature Date

WRITTEN COMPETENCY EXAMINATION RECORD

The assigned Testing Proctor must sign and date this form at each written competency test administration. **Trainees that do not pass the written competency examination after three attempts must retrain and repeat the testing process.**

Written Exam 1 _____ _____ ☐ Pass ☐ Fail
Coordinator Signature Date

Written Exam 1 _____ _____ ☐ Pass ☐ Fail
Coordinator Signature Date

Written Exam 1 _____ _____ ☐ Pass ☐ Fail
Coordinator Signature Date