Virginia Department of
Health Professions
Board of Nursing

VIRGINIA BOARD OF NURSING
PROGRAM EVALUATION

TO BE COMPLETED BY ADVANCED CERTIFICATION NURSE AIDE EDUCATION PROGRAMS

February 2024

ADVANCED CERTIFICATION EDUCATION PROGRAM EVALUATION

PROCESS: Pursuant to 18VAC90-26-60(A)(2) and 18VAC90-26-80(G), *The program coordinator shall prepare and submit a program evaluation report on a form provided by the board in the intervening year that a survey visit is not conducted.* Programs will be notified via email of the due date of the Program Evaluation, which programs will access on the Board of Nursing website and email, completed in full, to Christine.Smith@dhp.virginia.gov.

Pursuant to 18VAC90-26-60(B)(1) and 18VAC90-26-80(G), *The board shall receive and review the report of the survey visit or program evaluation report and may grant continued approval, place a program on conditional approval, or withdraw approval.*

NOTE: A separate form must be completed for each board approval number in your institution.

Program Name: _____ **Board Approval Number:** _____

Physical Address: _____ _____ _____
Street *City* *Zip*

Mailing Address: _____ _____ _____
Street *City* *Zip*

Coordinator: _____ **Email Address:** _____
*This will be the official email address listed in board records.

Program Phone Number: _____
*This will be posted publicly on the VBON website

Summary of Factual Data

Classroom Hours: _____ **Lab Hours:** _____ **Clinical Hours:** _____ **Total Hours:** _____

Current Student Enrollment: _____ **Start and End Dates of Current Class:** _____ - _____

Enter beginning and ending dates of classes since the last onsite survey inspection date.

Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Number of Students Admitted	Number of Students Completing Course

FACULTY ROSTER

18VAC90-26-30 and 18VAC90-26-80(C)

Following the example, list **all** instructors and resource personnel that have taught/assisted since the last on-site survey visit and include **all** table contents.

Full Name	Hire Date (mm/dd/yyyy)	Resignation Date (mm/dd/yyyy)	Role	Area of Instruction (check all that apply)	Date of Course-Work or Refresher Training (mm/dd/yyyy)	Nursing Credential/State of Licensure/License Number/Expiration Date (mm/dd/yyyy)
Example: Mary Who	01/02/2016	02/05/2022	☒ Coordinator ☒ Primary Instructor ☐ Other Instructor ☐ Other	☒ Classroom ☒ Skills Lab ☒ Clinical	12/06/2018	RN VA 00011112 11/30/2024
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		
			☐ Coordinator ☐ Primary Instructor ☐ Other Instructor	☐ Classroom ☐ Skills Lab ☐ Clinical		

Following the example, list **all** clinical facilities utilized by students since the last onsite survey visit.

CLINICAL AGENCIES ROSTER

Clinical Agency Name and Address Miles from Campus	Date of Last VDH Survey (mm/yyyy)	Agency Representative Name, Title, Phone Number and Email	Date of Contract/ Expiration Date (mm/dd/yyyy)	Date Last Used for Student Clinical Experiences (mm/dd/yyyy)	Number of Students/Hours per Clinical Unit per Day	Total Students/Hours in Direct Client Care
Example: The Best Nursing Home, 1010 Wonder Way, Richmond, VA 4 miles	01/2020	Mary Lou Who, RN Director of Nursing (331) 111-1111 mlw@Bestplace.com	03/10/2019- 03/10/2023	03/09/2022	6 students per day/8 hours each	12 students per term/80 clinical hours direct care per student

Complete the table below for those who should be copied on Board communications:

For high school programs, please include information for the CTE Coordinator, Principal, Superintendent and VDOE. For colleges, please include the college President.

Name	Title	Address	Phone number	Email
Example: Roberta Heart, RN	Coordinator	125 Lung Circle Richmond, VA 23233	(804)111-1111	rheart@htlg.com

ATTESTATIONS

***Initial* each box and sign the completed form.**

☐ I attest that the advanced certification education program is offered by an approved nurse aide education Program**.** **18VAC90-26-80(A)**

☐ I attest that the program develops and maintains individual student records of major skills taught and date of performance. At the completion of the program the student receives a copy of the record and a certificate of completion. **18VAC90-26-80(E)**

☐ I attest that a record that documents the disposition of complaints against the program is maintained. **18VAC90-26-80(E)**

☐ I attest that a record of the reports of graduates' performance on the NNAAP is maintained for a minimum of three years. **18VAC90-26-80(F)**

☐ I attest that the program coordinator shall prepare and submit a program evaluation report on a form provided by the board in the intervening year that a survey visit is not conducted. **18VAC90-26-80(G)**

By typing my signature below, I attest that the information submitted in this report is correct and demonstrates that the nurse aide education program is in compliance with Board of Nursing regulations.

(Continued on next page)

Name of Coordinator Completing this Report:

Date Signed:

This area intentionally left blank.