



Virginia Department of  
**Health Professions**  
Board of Nursing

VIRGINIA BOARD OF NURSING  
PROGRAM EVALUATION

*TO BE COMPLETED BY NURSE AIDE EDUCATION PROGRAMS*

February 2024

## **NURSE AIDE EDUCATION PROGRAM EVALUATION**

**PROCESS:** Pursuant to 18VAC90-26-60(A)(2), *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 the on the [Board of Nursing website](#) and email, completed in full, to [Christine.Smith@dhp.virginia.gov](mailto:Christine.Smith@dhp.virginia.gov).

Pursuant to 18VAC90-26-60(B)(1), *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:**  -



**FACULTY ROSTER**

*18VAC90-26-30*

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)
<b>Example: Mary Who</b>	01/02/2016	02/05/2022	<input checked="" type="checkbox"/> Coordinator <input checked="" type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Classroom <input checked="" type="checkbox"/> Skills Lab <input checked="" type="checkbox"/> Clinical	12/06/2018	RN VA 00011112 11/30/2024
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> Clinical		
			<input type="checkbox"/> Coordinator <input type="checkbox"/> Primary Instructor <input type="checkbox"/> Other Instructor	<input type="checkbox"/> Classroom <input type="checkbox"/> Skills Lab <input type="checkbox"/> 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
<b>Example:</b> 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.

<b>Name</b>	<b>Title</b>	<b>Address</b>	<b>Phone number</b>	<b>Email</b>
<b>Example:</b> Roberta Heart, RN	Coordinator	125 Lung Circle Richmond, VA 23233	(804)111-1111	<a href="mailto:rheart@htlg.com">rheart@htlg.com</a>

## ATTESTATIONS

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

I attest that the clinical facility being used is not subject to penalties pursuant to 42 CFR 483.151(b)(2).  
 N/A *(Required only for nursing-facility based programs; all others N/A)* **18VAC90-26-20(B)(1)(e)**

I attest that that board representatives may make unannounced site visits to the program.  
**18VAC90-26-20(B)(1)(g)**

I attest that no fees for any portion of the program, including any fees for textbooks or other required course materials have been imposed on any nurse aide who, on the date on which the nurse aide begins the program, is either employed or has an offer of employment from a nursing facility.  
 N/A *(Required only for nursing-facility based programs; all others N/A)* **18VAC90-26-20(B)(2)**

I attest that students received a copy of the applicable Virginia law regarding criminal history records checks for employment in certain health care facilities and the list of crimes which pose a barrier to such employment.  
**18VAC90-26-20(B)(3)**

I attest that all substantive changes to include a change in program coordinator, primary instructor, program ownership, physical location of the program or licensure status of the clinical facility will be reported to the board within 10 days of the change.  
**18VAC90-26-20(B)(4)**

I attest that the program develops and maintains individual student records of major skills taught and date of performance for a period of two years following each site or survey visit. At the completion of the program the student receives a copy of the record and a certificate of completion.  
**18VAC90-26-50(A)(1)**

I attest that a record of the reports of graduates' performance on the NNAAP is maintained for a period of two years following each site or survey visit.  
**18VAC90-26-50(A)(2)**

I attest that a record that documents the disposition of complaints against the program is maintained for a period of two years following each site or survey visit.  
**18VAC90-26-50(A)(3)**

I attest that at least 24 instructional hours are provided prior to direct contact of a student with a nursing facility client.  
**18VAC90-26-50(C)(2)**

I attest skills training is at least 40 hours of providing direct client care and that hours of observation are **not** included in the required 40 hours of skills training.  
**18VAC90-26-50(C)(3)**

I attest that if the program does not hold class for a period of one year, the board will be notified and the program will be placed on inactive status.  
**18VAC90-26-70(A)(1)**

*(Continued on next page)*

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.

**Name of Coordinator completing this Report:**

**Date Signed:**

*This area intentionally left blank.*