Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

Dialysis Technician Training Program Re-Approval Application

2015

Program Contact Information

Official name of program for publication _____

Address _____ City _____ State_____ Zip Code _____

Telephone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Parent Company Contact Information

Name of organization providing program _____

Address (**IF different from above**) _____ City _____ State _____ Zip_____

Telephone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Nurse Administrator Contact Information

Nurse Administrator (**Must be an Ohio Registered Nurse**) _____

Telephone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Please provide the following information:

- How many classes will be provided per year? _____ What is the expected average enrollment per class? _____
- Is off-site clinical instruction provided? Yes ❑ No ❑

  If yes, please list all clinical site(s) used: Please attach a separate piece of paper for additional listings.

  Name of clinical site _____

  Contact Person _____

  Address _____ City _____ State_____ Zip Code _____

  Telephone Number ( ) _____ Fax Number ( ) _____
- Will there be contracts with other facilities to provide clinical experience? Yes ❑ No ❑

  If yes, please list all other facilities used: Please attach a separate piece of paper for additional listings.

  Name of clinical site _____

  Contact Person _____

  Address _____ City _____ State_____ Zip Code _____

  Telephone Number ( ) _____ Fax Number ( ) _____

Please submit with Form B and $300 certified check or money order made payable to "Treasurer State of Ohio".
Incomplete submissions will NOT be processed.

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Program Name: _____

Program Administrator: _____

Verification of Rule Compliance:

Please indicate that the above mentioned dialysis technician training program meets the following standards.

	Yes	No
A curriculum plan that includes both classroom and clinical instruction which is a minimum of 320 hours, of which a minimum of 100 hours shall be theoretical instruction in a classroom setting and shall include content as outlined in Rules 4723-23-08 (A) OAC.	❑	❑
The program is administered by a registered nurse who meets the requirements as outlined in Rule 4723-23-08(B) OAC.	❑	❑
Policies which reflect the responsibilities of the nurse administrator as outlined in Rule 4723-23-08(D) OAC.	❑	❑
Qualifications of faculty as outlined in Rule 4723-23-08(C) OAC.	❑	❑
Program policies as outlined in rule 4723-23-08 (E) OAC.	❑	❑
Policies for replacement in the event of a vacancy of the nurse administrator.	❑	❑
Policy for notification of the Board when a decision is made to close a training program.	❑	❑

I attest that the above information represents accurately the information on file for the specified dialysis technician training program.

Signature: _____ Date: _____