

**CERTIFIED NURSE ASSISTANT ORIENTATION, IN-SERVICE, AND  
NURSE ASSISTANT TRAINING PROGRAM  
COMBINED RENEWAL APPLICATION (SNF/ICF)**

**INSTRUCTIONS:** Complete this renewal form and sign the attestation at the end. ALL FIELDS MUST BE COMPLETED. Submit this form and all supporting documents to [TPRU@cdph.ca.gov](mailto:TPRU@cdph.ca.gov), or by fax to 916-636-6760, no more than 90 days prior to your program's expiration date. DO NOT SEND BY U.S. MAIL. Always use the most current Training Program Review Unit (TPRU) forms when submitting your application. All forms can be found on [TPRU website](#). Attach additional pages if more space is needed to complete the application.

**FACILITY INFORMATION**

Facility Name: \_\_\_\_\_

Facility Physical Address: \_\_\_\_\_

Facility Mailing Address: \_\_\_\_\_  
(If different than Physical Address)

Facility Phone Number: \_\_\_\_\_

Facility Identification Training Number: F – \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**CONTACT INFORMATION**

Facility Administrator Name (Print): \_\_\_\_\_

Facility Administrator Email Address: \_\_\_\_\_

Director of Nursing (DON) Name (Print): \_\_\_\_\_

DON Email Address: \_\_\_\_\_

Director of Staff Development (DSD) Name (Print): \_\_\_\_\_

DSD Email Address: \_\_\_\_\_ DSD Number, if known: \_\_\_\_\_

DSD's Nursing License Number: \_\_\_\_\_ Check one:  LVN or  RN

- If TPRU has not approved this DSD for your facility, **SUBMIT** a [CDPH 279](#) DSD/Instructor application and a current resume.

**SECTION A: CERTIFIED NURSE ASSISTANT (CNA) ORIENTATION PROGRAM**

Check the box that applies to your facility:

1. The CNA Orientation Program has not changed since our last renewal. **SUBMIT** a copy of the previously approved CDPH 278A form that your facility is using.
2. There have been changes made to the CNA Orientation Program since our last renewal. **SUBMIT** the following:
- A new [CDPH 278A](#) form.
  - Lesson Plan for a Direct Patient Care Skill (CDPH 278A, page 2, #1).
  - Skills Return Demonstration Record (CDPH 278A, page 2, #2).

**SECTION B: CNA IN-SERVICE TRAINING PROGRAM**

**SUBMIT** the following for your In-service Training Program:

1. **Three-month in-service schedule for future months.** If your facility's In-service Program expires on 05/31/2022, you will submit schedules for June, July, and August of 2022 or later.

You **MUST** include the following on your in-service schedule:

- a. Facility name, the month, and YEAR of the schedule (2022, 2023, etc.).
- b. The exact date and time of each in-service.
- c. Minimum of two in-service Course Titles listed each month. Course Titles listed on your schedule **should be different** from your last renewal.
- d. The schedule must clearly show that in-services are **available to all shifts**. For example, a facility may have in-services from 0600-0700 for the Night shift, 1400-1500 for the Day shift, and 1600-1700 for the PM shift.

**Example:** JUNE 2022

6/8 Choking Prevention & Intervention 6:00am – 7:00am, 2:00pm – 3:00pm  
6/10 Choking Prevention & Intervention 4:00pm – 5:00pm  
6/21 Dementia: Sundowning 6:00am – 7:00am, 2:00pm – 3:00pm  
6/23 Dementia: Sundowning 4:00pm – 5:00pm

2. **One in-service lesson plan** from the Course Titles listed on your 3-month in-service schedule. The lesson plan **MUST** include:
- a. Course Objectives (Student performance standards).
  - b. Course Content (Outline of the topics to be covered in the in-service).
  - c. Teaching Method (lecture, skill demonstration, discussion, video).
  - d. Evaluation Method (How the results of the training are evaluated: quiz, questions and discussion, skill return demonstration).

3. **In-service Sign-in Sheet**

Check the box that applies:

- Our facility uses the **CDPH 278D In-service Training Attendance Sign-in Sheet** template for the CNA In-service program.
- Our facility uses its own sign-in sheet for the CNA In-service program.

**SUBMIT** a copy. The sign-in sheet **MUST** include the following:

- a. The name of your facility.
- b. Date of the in-service.
- c. Start Time and End Time of the In-service.
- d. In-service Course Title.
- e. Instructor's name (typed/printed) and Instructor's signature.
- f. Participant's name (typed/printed) and Participant's signature.
- g. Participant's CNA (or HHA) certification number.

**SECTION C: DECLARATION OF PARTICIPATION IN APPROVED TRAINING PROGRAMS**

Check the **box** for the option that applies to your facility. (*ONLY check one*)

**Option 1:** Our licensed facility directly conducts a Nurse Assistant Training Program (NATP) for our Nurse Assistant employees. All NATP training is conducted by our licensed facility at the training site (facility) address listed above, or on-line as approved by the Department. **Complete Sections D and E.**

**Option 2:** Our licensed facility provides NATP training for our Nurse Assistant employees through a written agreement (contract) with the Department approved NATP listed below:

Name of Contracted NATP: \_\_\_\_\_

Address of Contracted NATP: \_\_\_\_\_

Program ID Number of Contacted NATP (ID# begins with S or F): \_\_\_\_\_

**SUBMIT** a [CDPH 278SC](#) for the new renewal period. **Complete Section E.**

**Option 3:** Our licensed facility *only* hires Certified Nurse Assistants with a valid certification. **Complete Section E.**

**SECTION D: RENEWAL OF NURSE ASSISTANT TRAINING PROGRAM**

(*ONLY complete if you checked Option 1 in Section C*)

1. **SUBMIT** the following for your NATP:

[CDPH 276F](#)

Daily Training Program Schedule ([CDPH 276B](#))

2. Our facility is using the current version of the [CDPH 276A](#) Skills Check List and the [CDPH 276C](#) Individual Student Record:  Yes  No

3. **SUBMIT** the following if changes have occurred since your last renewal:

[CDPH 276P](#) Administrative Policies and Procedures  Job Descriptions

Organizational Chart of your NATP  Instructor Monitoring Tool

Four Lesson Plans (if Curriculum changed)

4. **Check the box that applies to your facility:**

The DSD is the only instructor for our NATP.

We have additional NATP instructors, and they are listed below:

Name and Professional Title (LVN or RN)	License Number	DSD Number (if known)

• If TPRU has not approved any of the listed NATP instructors for your facility, **SUBMIT** a [CDPH 279](#) DSD/Instructor application and a current resume.

**SECTION E: COMPLIANCE STATEMENTS AND ATTESTATIONS**

1. A minimum of **24** hours of varied in-service training must be made available each year to your CNA employees on all shifts, California Code of Regulations, Title 22 (22 CCR) §71847(e).
2. Your CNA employees must be paid at least their normal hourly wage if attending in-services at your facility outside of their regularly scheduled work shifts, 22 CCR §71847(e)(1).
3. In-services must be at least one hour in length and in whole hours increments (1 hour, 2 hours, etc.) for a CNA to be able to use the in-service hours towards the 48 hours of CEUs needed for their CNA certification renewal.
4. Must provide a minimum of 5 hours of in-service training each year on dementia-specific topics, California Health and Safety Code (HSC) §1263(c).
5. Must provide a minimum of 4 hours of in-service training each two-year renewal period on preventing, recognizing, and reporting instances of resident abuse, including instruction on preventing, recognizing, and reporting residents’ rights violations, HSC §1337.1(e)(2).
6. In-service records must be kept for a minimum of **four years**, 22 CCR §71849(d). This includes, but is not limited to, in-service lesson plans, quizzes, and in-service sign-in sheets.
7. There should be variation in the in-service topics from one renewal period to the next. In-service topics should address areas of insufficient knowledge or skill level as determined by your facility’s annual performance evaluations of its CNA employees and areas related to patient care that your facility received deficiencies in following your last licensing survey, 22 CCR §71847(f).
8. Your facility’s in-service training program must be renewed every two years, 22 CCR §71847(h).
9. Your facility must submit a CDPH 279 DSD application to TPRU within 30 calendar days following the employment of a new DSD, 22 CCR §71847(h).

**We attest under the penalty of perjury that the information provided by our facility is correct and accurate, and that we will abide by all applicable codes, regulations and rules pertaining to our facility’s training programs.**

Facility Administrator Signature:	Date:
DON Signature:	Date:
DSD Signature:	Date:

<i>California Department of Public Health Use Only</i>	
<input type="checkbox"/> Approved	By: _____ Date: _____ Training Program Review Unit Representative