STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

NURSE'S AIDE TRAINING PROGRAM SCHEDULE

NAME OF INSTITUTION: _____

ADDRESS: _____

_____

PHONE NUMBER: (_____) _____

This institution intends to provide a nurse's aide training program as follows:

Dates and Hours of Training

CLASSROOM	*CLINICAL*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

REMEMBER: ***Ongoing approval of the institution's nurse's aide training program is contingent upon an on-site review of the program by representatives of The Department of Public Health, Division of Health Systems Regulation.***

_____ _____

Primary Training Instructor **Date**

Phone: (860) 509-7444
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