

## Community Instructor Application

TODAY'S DATE

Use this form to apply to become a DSHS approved Community Instructor for long-term care workers for the following courses:

- Core Basic Training
- Population Specific
- Nurse Delegation Core
- Nurse Delegation Diabetes
- Dementia Specialty Training
- Mental Health Specialty Training
- Expanded Specialty Training (Traumatic Brain Injury Specialty and Diabetes Specialty)

To request approval to teach Orientation, Safety Training, and Continuing Education, use Community Instructor Training Program Application and Updates, 15-551. All other DSHS course approval request forms can be downloaded on the [Training Program and Instructor Application Forms](#) page.

Submit this form with the Community Instructor Training Program Application and Updates, 15-551. Email your questions and submit your application to [TrainingApprovalTPC@dshs.wa.gov](mailto:TrainingApprovalTPC@dshs.wa.gov).

### Section 1. Instructor, Training Program Information and Courses Requested

INSTRUCTOR'S NAME		DATE OF BIRTH
INSTRUCTOR'S CONTACT INFORMATION		
PHONE NUMBER (AREA CODE) (    )	CELL NUMBER (AREA CODE) (    )	EMAIL ADDRESS
NAME OF BUSINESS		
If this is a new training program, please leave the Training Program Name and Number blank.		
TRAINING PROGRAM NAME		TRAINING PROGRAM NUMBER

Select the courses you plan to teach and complete Appendix A:

- Core Basic Training                       Population Specific  
 Nurse Delegation Core                       Nurse Delegation Diabetes

Select the Specialty Training you plan to teach and complete Appendix B:

- Dementia Specialty Training     Mental Health Specialty Training     Traumatic Brain Injury Specialty Training  
 Diabetes Specialty Training

### Section 2. General Community Instructor Qualifications [WAC 388-112A-1240](#)

1. Are you 21 years old or older?  Yes  No
2. Are you an owner or administrator of an adult family home, assisted living facility, enhanced services facility, nursing home, home care agency, or supported living in Washington?  Yes  No  
 If **yes**, please list the type of license and the license number. Supported living providers list the type of certification and certification number. If **no**, leave blank.  
 Type of license or certification \_\_\_\_\_  
 License or certification number \_\_\_\_\_
3. Are you a health care or social service professional, such as an RN, LPN, HCA, NAC, EMT, or other DOH credential?  Yes  No  
 If **yes**, list any licenses or certifications you hold in Washington. If **no**, leave blank.  
 Type of license or certification \_\_\_\_\_  
 License or certification number \_\_\_\_\_
4. Have you ever had a professional health care, adult family home, assisted living or social services license or certification revoked in Washington State?  Yes  No  
 License or certification number \_\_\_\_\_ Date of revocation \_\_\_\_\_

5. Highest level of education:  High School or equivalent  Associate's  Bachelor's  Master's  PhD
6. A certificate of completion for the DSHS Adult Education class is required to teach Core Basic Training, Dementia Specialty Training, Mental Health Specialty Training, and Expanded Specialty Training. Have you attached your Adult Education certificate to this application if required?
- Yes  No

**Appendix A. Complete this section to teach Long-Term Care Worker Basic Training, Population Specific, Nurse Delegation Core and Nurse Delegation Diabetes [WAC 388-112A-1240](#)**

**A.1. Work Experience**

List the **one-year** of work experience you have had in the last five years in an adult family home, assisted living facility, enhanced services facility, supported living, or in-home care setting.

<b>Employer 1</b>	EMPLOYER		YOUR TITLE	
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NUMBER (AREA CODE) (    )	
DATES IN THIS POSITION From        To		HOURS PER WEEK	SUPERVISOR'S NAME	
<b>Employer 2</b>	EMPLOYER		YOUR TITLE	
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NUMBER (AREA CODE) (    )	
DATES IN THIS POSITION From        To		HOURS PER WEEK	SUPERVISOR'S NAME	

**A.2. Teaching Experience**

List **100 hours** of experience teaching adults in an appropriate setting on topics directly related to basic training or basic training topics that may be offered as continuing education. If you do not meet this requirement, see [WAC 388-112A-1240\(4\)](#) for alternative teaching requirements. If you will administer tests, do you have experience or training in assessment and competency testing?  Yes  No

<b>Employer 1</b>	EMPLOYER		YOUR TITLE		
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NUMBER (AREA CODE) (    )		
DATES IN THIS POSITION From        To		SUPERVISOR'S NAME			
TOPICS / SUBJECT MATTER TAUGHT			LENGTH OF CLASS X	NO. OF TIMES CLASS TAUGHT	= TOTAL CLASS HOURS
<b>Employer 2</b>	EMPLOYER		YOUR TITLE		
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NUMBER (AREA CODE) (    )		
DATES IN THIS POSITION From        To		SUPERVISOR'S NAME			

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS X	NO. OF TIMES CLASS TAUGHT	= TOTAL CLASS HOURS

**Appendix B. Complete this section to teach Dementia Specialty Training [WAC 388-112A-1285](#), Mental Health Specialty Training [WAC 388-112A-1270](#), and/or Expanded Specialty - Traumatic Brain Injury Specialty and Diabetes Specialty (rollout summer 2021) [WAC 388-112A-1292](#)**

**B.1. Work Experience**

List the **two-years of** full-time equivalent work experience **with** the specialty populations in this section.

<b>Employer 1</b>	EMPLOYER	YOUR TITLE
Type of care setting: <input type="checkbox"/> AFH <input type="checkbox"/> ALF <input type="checkbox"/> ESF <input type="checkbox"/> In-home <input type="checkbox"/> Supported living <input type="checkbox"/> Other		
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) (    )
DATES IN THIS POSITION From        To	HOURS PER WEEK	SUPERVISOR'S NAME

Under this employer, I had specific experience in the following:  
 Dementia     Mental Health     Traumatic Brain Injury     Diabetes

<b>Employer 2</b>	EMPLOYER	YOUR TITLE
Type of care setting: <input type="checkbox"/> AFH <input type="checkbox"/> ALF <input type="checkbox"/> ESF <input type="checkbox"/> In-home <input type="checkbox"/> Supported living <input type="checkbox"/> Other		
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) (    )
DATES IN THIS POSITION From        To	HOURS PER WEEK	SUPERVISOR'S NAME

Under this employer, I had specific experience in the following:  
 Dementia     Mental Health     Traumatic Brain Injury     Diabetes

**B.2. Teaching Experience**

List **200 hours** of experience teaching long-term care related subjects. If you documented this requirement in Appendix A, you may leave this section blank.

Do you have experience or training in assessment and competency testing?  Yes  No

<b>Employer 1</b>	EMPLOYER	YOUR TITLE
EMPLOYER'S ADDRESS		EMPLOYER'S PHONE NUMBER (AREA CODE) (    )
DATES IN THIS POSITION From        To	SUPERVISOR'S NAME	

TOPICS / SUBJECT MATTER TAUGHT	LENGTH OF CLASS X	NO. OF TIMES CLASS TAUGHT	= TOTAL CLASS HOURS

<b>Employer 2</b>	EMPLOYER		YOUR TITLE	
EMPLOYER'S ADDRESS			EMPLOYER'S PHONE NUMBER (AREA CODE) (    )	
DATES IN THIS POSITION From        To		SUPERVISOR'S NAME		
TOPICS / SUBJECT MATTER TAUGHT		LENGTH OF CLASS <b>X</b>	NO. OF TIMES CLASS TAUGHT	= TOTAL CLASS HOURS

**B.3. Education**

Does your work experience listed in B.1. total five or more years? If it does not, you must meet **BOTH**:

The **degree/credential** requirement: BA, BS, RN, or a mental health professional (as documented in Section 2 of this application);

**AND**

The **education** requirement on topics directly related to dementia, mental health, traumatic brain injury, and/or diabetes: one year of education in college classes **or** 80 hours of seminars, conferences, and continuing education.

If you do not meet both of the requirements listed above, you **may** use your **five years of full-time equivalent work experience** with people who have mental health, dementia, and/or expanded special topic diagnoses to substitute for either the degree requirement **or** the education requirements listed above:

If you plan to use work experience, which requirement will you substitute?

**Check one box only:**

**Degree** **OR**  **One year of education**

**IMPORTANT: Attach documentation that confirms** your degree, licensure, and/or education (such as transcripts, diplomas, CE certificates, etc.).

NAME OF EDUCATION COURSE, CONFERENCE, OR EVENT	MONTH AND YEAR ATTENDED	HOURS / CREDITS	FOR EACH AREA OF STUDY, BRIEFLY DESCRIBE HOW RELATES TO THE TOPIC(S) OF MENTAL HEALTH, DEMENTIA, TRAUMATIC BRAIN INJURY, AND/OR DIABETES

### Section 3. Attestation of Accuracy

Read and complete the following attestation.

I certify and understand that:

- The information I have provided to the department in this application and during the application process is subject to investigation and verification.
- The department may obtain additional information, verification, and/or documentation related to my answers or information.
- The information provided in this application and in all additional documents is true, complete, and accurate.
- Providing false or inaccurate information are cause for rejection of this application.

SIGNATURE

DATE

JOB TITLE

### Section 4. Is your application complete?

Did you remember to:

- Attach copies of your Specialty Training and/or Adult Education certificates of completion, if required
- Attach [Contractor Intake](#) form (DSHS 27-043) with copy of business license (new applicants only)
- Complete Section 3: Attestation of Accuracy

Email your questions and submit your application with supporting documentation (if required) to [TrainingApprovalTPC@dshs.wa.gov](mailto:TrainingApprovalTPC@dshs.wa.gov).

For more information about long-term care worker training, please visit the [DSHS Training Requirements and Classes page](#).