

ASSISTED LIVING ADMINISTRATOR TRAINING COURSE APPLICATION FOR TRAINING CURRICULUM

Mail completed form, course curriculum, and all individual trainer applications to: **UW-Oshkosh
 Assisted Living Administrator Training
 CCDET
 800 Algoma Blvd
 Oshkosh, WI 54901-8688**

If you have questions regarding this application form, contact: **cbrfrng@uwosh.edu**

Section I. Entity Information

Name – Entity / Agency Representative or Individual Offering Course

Mailing Address

City	State	Zip Code	County
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Telephone	FAX	E-mail Address
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Web Address (if any)

Type of Entity / Agency / Individual Offering Course

- | | |
|---|---|
| <input type="checkbox"/> Assisted Living Facility Administrator | <input type="checkbox"/> Health Professional (<i>Indicate professional discipline below.</i>) |
| <input type="checkbox"/> Industry Association | |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Other (<i>Specify below.</i>) |
| <input type="checkbox"/> Trainer | |

Section II. Trainers

Indicate below the names of the trainers for each core area. If there are multiple trainers for any core area(s) or topic(s), you must include the names of all trainers. Use additional sheets, if necessary. **NOTE: Each trainer must complete DQA form F-00157, Assisted Living Administrator Training Course Trainer Approval Application. All Trainer Approval Application(s) must be attached to this form.**

Required Core Competency Area	Hours of Training	Name of Trainer(s)
Leadership/Management Skills		
Resident Care and Services		
Resident Rights, Advocacy, and Legal Issues		
Physical Environment/Life Safety		
Human Resources Management		
Financial Management		

Section III. Determination of Competency

Describe below what systems or methods you or your trainers will use to determine that the individuals trained with this curriculum are competent in the core competency areas.

Section IV. Verification of Course Completion

- A. Attach a copy of the certificate you will issue to Assisted Living Administrators who have successfully completed your Department approved course. The certificate must include (1) the person's name, (2) the name of the course, (3) the entity/agency/individual that provided the course, and (4) the Assisted Living Administrator Course approval number (which will be provided to you upon approval of the course and trainers).
- B. Indicate below the individual(s) who is/are authorized by the training entity/agency/individual to sign certificates of completion of the Assisted Living Administrator Training Course.

Name – Authorized Signee	Name – Authorized Signee
Name – Authorized Signee	Name – Authorized Signee

Section V. Attestation

I hereby attest and confirm that the attached curriculum submitted by

Name – Entity / Agency Representative or Individual

for Department approval complies with the requirements for an Assisted Living Administrator Training Course specified by the Wisconsin Department of Health Services. The curriculum includes the six core competency areas required by the Department and the training curriculum will cover all of the specified areas. The training will consist of at least sixty (60) hours of training and will be conducted by trainers who have been approved by the Department in the core competency area(s) for which they will provide training.

I attest that all of the information provided and/or attached to this application is true and correct. I understand that I am responsible for the information included in this application and for ensuring that the ongoing curriculum continues to meet the requirements established by the Department.

SIGNATURE – Entity / Agency Representative or Individual	Date Signed
Name – Entity / Agency Representative or Individual (Print or type.)	Title