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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02288 (05/2019) | **STATE OF WISCONSIN** |
| **WisCAREGIVER CAREER PROGRAM – REGISTRATION AGREEMENT** |
| **Return completed and signed form to the Wisconsin Department of Health Services using one of the three options below:** |
| **US Mail:** DHS / Division of Quality AssuranceOffice of Caregiver QualityPO Box 2969Madison, WI 53701-2969 | **Email:** DHSCaregiverCareer@dhs.wisconsin.gov | **Fax:** 608-224-5770 |
| First Name      | MI  | Last Name      |
| Address – Street       | City      | State   | Zip Code      |
| County      | Phone No. *(including area code)*      | Email Address      |
| Date of Birth *(MM/dd/yyyy)*      | Education – Highest Level Completed      |
| Race *(Optional)*[ ]  American Indian/Alaskan Native [ ]  Asian/Pacific Islander [ ]  Black/African American [ ]  Spanish/Hispanic/Latino [ ]  White |
| How did you hear about this training?[ ]  TV Ad [ ]  Radio Ad [ ]  Print Ad [ ]  Social Media [ ]  Google Search [ ]  WisCaregiver.com |
| **WisCaregiver Career Program Agreement** |
| *All boxes below must be checked as a requirement to register for the WisCaregiver Career Program.* |
| [ ]  | I am less than 18 years of age. |
| [ ]  | I am not currently listed on the Wisconsin Nurse Aide Registry. *(Search the registry at* [*https://wi.tmuniverse.com/*](https://wi.tmuniverse.com/) *.)* |
| [ ]  | I agree to share information and allow information sharing with the University of Wisconsin-Oshkosh Center for Community Development, Engagement, and Training (CCDET); the Wisconsin Department of Health Services (DHS); and, the participating training programs for purposes of the WisCaregiver Career Program. |
| [ ]  | I agree to register for an approved nurse aide training program within 90 days of completing the registration survey. *(See* [*www.WisCaregiver.com*](http://www.WisCaregiver.com) *for a listing of nurse aide training programs.)* |
| [ ]  | I agree to forward email received upon WisCaregiver Career Program registration to the approved nurse aide training program. |
| [ ]  | I agree to successfully complete an approved nurse aide training program. |
| [ ]  | I agree to schedule a competency test within three months of completing training. |
| [ ]  | I agree to successfully complete competency testing within two attempts. |
| [ ]  | I agree to secure employment in a participating Wisconsin nursing home within two months of completing competency testing. |
| [ ]  | I agree to work full-time or part-time in a participating Wisconsin nursing home as a nurse aide for at least six months in exchange for nurse aide training and testing at no cost to me (full-time and part-time as defined by the nursing home). |
| [ ]  | I agree to participate in a secure online survey at the conclusion of my participation in the WisCaregiver Career Program. |
| [ ]  | I agree to pay the Wisconsin DHS for the cost of training and/or competency testing if I do not complete training and/or pass the competency test within two attempts and work for six months in a participating Wisconsin nursing home as a nurse aide. |
| [ ]  | I understand that paying the $500 retention bonus to me after working at a participating WisCaregiver Career Program nursing home as a nurse aide for six continuous months is the sole responsibility of the nursing home and I agree to release from liability and waive any right to sue the Wisconsin DHS from any and all claims related to the failure of the nursing home to pay the retention bonus. |
| **SIGNATURE** – Student | Date Signed *(MM/dd/yyyy)* |
| **SIGNATURE** – Parent | Name – Parent *(Print or type.)* | Date Signed *(MM/dd/yyyy)* |