|  |  |
| --- | --- |
| DEPARTMENT OF HEALTH SERVICESDivision of Quality AssuranceF-03092 (08/2022)  | **STATE OF WISCONSIN** |

##### NURSE AIDE TRAINING PROGRAM WAIVER OR VARIANCE REQUEST

* When this request is submitted, **all information is required**.
* If spaces allotted are not sufficient for your response, **attach additional pages as needed.**
* Personal information collected on this form will be used during the review process and for no other purpose.
* For questions about completion of this form, refer to the [Waivers or Variances: Nurse Aide Program](https://www.dhs.wisconsin.gov/regulations/waiver-variance-nurse-aide.htm) or contact the Nurse Aide Training and Registry Team
* Return this completed and signed form to DHSWIDQA\_NATCEP@dhs.wisconsin.gov

|  |  |
| --- | --- |
| Name – Program      | Program Approval No.      |
| Type of Request: [ ]  Approval [ ]  Variance [ ]  Exception |
| [ ]  Waiver [DHS 129.03(55)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.03%2855%29)“Waiver" means the department's approval of an **exemption** requested by a health care provider from a requirement of this chapter. [ ]  Variance [DHS 129.03(54)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.03%2854%29)”Variance" means the department's approval of an **alternate requirement** requested by a health care provider in place of a requirement of this chapter. |
| Time Period of Request[ ]  Permanent [ ]  Temporary – **From** *(MM/dd/yyyy)***:** |       | **To** *(MM/dd/yyyy)***:** |       |
| *The following three items have expandable fields.* |
| Rule from which waiver or variance is requested: |
| [ ]  [DHS 129.06(1)(a)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06%281%29%28a%29) The primary instructor for a training program shall be a registered nurse licensed to practice in Wisconsin, who has at least 2 years of experience working as a registered nurse, of which at least one year of experience shall be actual work experience in providing care in a nursing home that meets the requirements of sections 1919(a), (b), (c) and (d) of the Social Security Act[ ]  [DHS 129.06(1)(b)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06%281%29%28b%29) Notwithstanding par. [(a)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06%281%29%28a%29), the primary instructor for a training program conducted by a hospital shall have at least one of the 2 years’ experience working as a registered nurse in a hospital.[ ]  [DHS 129.06(1)(e)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06%281%29%28e%29) The primary instructor shall attend a training course for instructors approved by the department under sub. [(3)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06%283%29). The department may waive this requirement for an instructor who has taken a substantially equivalent course or who has substantially equivalent training or clinical experience.[ ]  [DHS 129.07(2)(c)1.](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.07%282%29%28c%291.) Access to a clinical setting approved by the department that is adequate to meet the needs of the program.[ ]  [DHS 129.03(8)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.03%288%29)“Clinical setting" means one of the following:**(a)** A practice setting where care and treatment of clients occur.**(b)** A health care-related setting, where care and treatment of clients occurs[ ]  Other:       |
| How will this request not adversely affect the health, safety or welfare of any client: |
|       |
| **If variance request:** |
| Proposed alternative to the rule: |
|       |
| How is the proposed alternative to a rule in the interest of more effective training or testing programs or management? |
|       |
|

|  |
| --- |
| **If waiver request:** |
| How does the requirement that the program seeks waiver from result in unreasonable hardship or is infeasible as applied to the training program or competency evaluation program? |
|       |

 |
| Name – Program Representative      | Title      |
| **SIGNATURE** – Person Completing Form | Date Signed *(MM/dd/yyyy)*      |
| DQA USE ONLY |
| [ ]  Deny Request [ ]  Approve Request – Expiration Date *(MM/dd/yyyy):* |       |
| Comments *(expandable field)* |
|  |
| **This approval may be rescinded at any time upon a determination by the Department.** |
| **SIGNATURE** – | Date Signed *(MM/dd/yyyy)*      |