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| DEPARTMENT OF HEALTH SERVICES Division of Quality Assurance  F-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](mailto:WIDQA_NATCEP@dhs.wisconsin.gov)
* Return this completed and signed form to [DHSWIDQA\_NATCEP@dhs.wisconsin.gov](mailto:DHSWIDQA_NATCEP@dhs.wisconsin.gov)

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| 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(55))“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(54))”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(1)(a)) 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(1)(b)) Notwithstanding par. [(a)](https://docs.legis.wisconsin.gov/document/administrativecode/DHS%20129.06(1)(a)), 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(1)(e)) 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(3)). 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(2)(c)1.) 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(8))“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: | | | | | | |
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| **If variance request:** | | | | | | |
| Proposed alternative to the rule: | | | | | | |
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| How is the proposed alternative to a rule in the interest of more effective training or testing programs or management? | | | | | | |
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| |  | | --- | | **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)* | | | | | | |
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| **This approval may be rescinded at any time upon a determination by the Department.** | | | | | | |
| **SIGNATURE** – | | | | | | Date Signed *(MM/dd/yyyy)* |