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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62692 (06/2024) | | | **STATE OF WISCONSIN**  DHS 129.14 | | | | | | |
| **FEEDING ASSISTANT TRAINING PROGRAM INSTRUCTOR APPLICATION** | | | | | | | | | |
| **I. INTRODUCTION** | | | | | | | | | |
| The Department of Health Services (DHS) 129.14 states that the programs shall determine the appropriate qualifications for their instructor(s) based on the needs of the selected clients and the nursing home.   * Direct questions regarding completion of the application to: [dhsdqafeedingassistantprogram@dhs.wisconsin.gov](mailto:dhsdqafeedingassistantprogram@dhs.wisconsin.gov) * Submit the completed application to: [dhsdqafeedingassistantprogram@dhs.wisconsin.gov](mailto:dhsdqafeedingassistantprogram@dhs.wisconsin.gov). | | | | | | | | | |
| Instructor Full Name *(****Do not use nicknames.)*** | | | | | | | | | |
| Last | First | | | M.I. | | | | | |
| Title | | | | | | | Sex  Female  Male | | |
| Current Mailing Address (Street/P.O. Box) | | | City | | | | | State | ZIP Code |
| Phone Number (Work) | | | Email Address | | | | | | |
| Name – Training Program You Intend to Instruct | | | | | | | | | |
| **II. CREDENTIALS** (*Attach copy of license/credential, if applicable. Attach additional pages, if necessary.)* | | | | | | | | | |
| Type of License/Credential | | State of Issue | | | Date Issued (mm/dd/yyyy) | Expiration Date (mm/dd/yyyy) | | | |
| **III. EXPERIENCE** (*Attach resume or fill out below*.) | | | | | | | | | |
| Place of Employment | | | | | Date of Hire (mm/dd/yyyy) | Date of Separation (mm/dd/yyyy) | | | |
| Qualifications | | | | | | | | | |
| Place of Employment | | | | | Date of Hire (mm/dd/yyyy) | Date of Separation (mm/dd/yyyy) | | | |
| Qualifications | | | | | | | | | |
| Place of Employment | | | | | Date of Hire (mm/dd/yyyy) | Date of Separation (mm/dd/yyyy) | | | |
| Qualifications | | | | | | | | | |
| **IV. ATTESTATION** | | | | | | | | | |
| I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both (per Wis. Stat. § 946.32). | | | | | | | | | |

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| **SIGNATURE** – Applicant/Program Designee | | Date Signed |
| Name – Applicant *(Print or type)* | Title | |

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| **DHS USE ONLY** | | | | | |
| Approved/Acknowledged | | | Entered Database | Date: | |
| Denied | Reason for Denial: | | | | |
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| Name – Reviewer | | Title | | | Date Reviewed |