Reset Form

TRAIN THE TRAINER ADULT EDUCATION WAIVER REQUEST

State Form 9900485 (10-26)
INDIANA DEPARTMENT OF HEALTH

This form is only to be utilized by individuals to formally request a waiver of the requirement of the adult education component of Train the Trainer related to 42 CFR 483.152(a)(5)(ii) stating, "Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides."

Once a determination is made regarding this request, the applicant will be notified of the decision. Simply submitting a waiver request does not guarantee a waiver approval.

SECTION 1 – APPLICANT INFORMATION

Full name of applicant (first, middle initial, last): _____

Nursing License Number: _____ Expiration Date (MM/DD/YYYY): _____

Email Address: _____ Telephone Number: _____

SECTION 2 – WAIVER REQUEST

I am requesting a waiver for the following Train the Trainer (TTT) Adult Education:

☐ Nurse Aide Training (NAT)

☐ Qualified Medication Aide Training (QMAT)

Select the qualifying reason for the waiver request:

☐ I have already attended the adult portion of TTT for NAT or QMAT and are now attending TTT for the other program type.

- o I previously attended TTT on the following date: _____

☐ I have at least one (1) year of experience in teaching adults in a classroom setting.

- o Provide detailed description of adult classroom teaching experience explaining where they taught, what content was taught, who the adult learners were (nurses, aides, families, residents, etc.), and the approximate dates of instruction.
- o A formal letter from the facility or organization where the adult teaching occurred, verifying:
  - • The applicant's role and responsibilities
  - • Confirmation that the teaching was in a classroom setting
  - • The total duration of adult teaching (continuous or cumulative 12 months)
  - • Contact information for verification

☐ I have at least one (1) year experience of clinical supervision of nurse aides. This can be twelve (12) continuous months, or twelve (12) cumulative months over multiple years.

- o Written explanation of the extent of their supervisory role of nurse aides.
- o A signed letter from the employer confirming:
  - • That the applicant served in a supervisory capacity over nurse aides
  - • The total duration of supervision (≥12 continuous months OR ≥12 cumulative months)
  - • The nature of supervision (e.g., clinical oversight, skills monitoring, resident care coordination)
  - • Contact information for verification