

Application for renewal of certification as a worker organization to train nursing home workers under Minnesota Statutes 181.214

Your application will not be processed or will be delayed unless you complete all sections of this application. If you require additional space, use a separate piece of paper and attach.

Note: In seeking approval, the worker organization shall submit all required information, and other information the worker organization believes relevant, to the Nursing Home Workforce Standards Board (NHWSB or the board) in the form or manner required by the board. NHWSB may request additional information necessary to determine an applicant's eligibility for approval or schedule interviews to clarify information submitted.

NHWSB may withdraw its certification of a worker organization if the worker organization fails to enforce those representations made to NHWSB in obtaining certification.

Applicant information (write legibly in ink or type)

Federal employer tax number (FEIN) or Minnesota Tax ID (if applicable)

Legal business name

Telephone number

Website address

Physical business address (P.O. box not acceptable), city, state, ZIP code

Public mailing address (P.O. box acceptable), city, state, ZIP code

Contact person, phone number, email address for person filling in the form

Contact person, phone number, email address for the training schedules moving forward

Adherence to curriculum and standards

(checkbox) I have reviewed the updated standards established by the board and will update our training in accordance with these updated standards.

(checkbox) I have reviewed the updated curriculum requirements established by the board and will adhere to these requirements as updated.

(checkbox) I have or will update our training and trainers, notifying them of the changes to the current curriculum. Updates will be completed **within XX** days of submission of this document.

Changes to capacity

(checkbox) We have no changes to our capacity.

(checkbox) We have had the following changes to our capacity and the rest remains the same. (Indicate below where there are changes to your capacity to provide training.)

Number of people your organization can train given that each person will need at least a one-hour training session every two years and the organization will need to be reasonably available for follow-up inquiries during and after the training:

Number of people in a year.

Number of people per month.

What is the capacity your organization has for the following training each month:

Number of buildings, assuming each building will need one to three training sessions.

Number of in-person meetings or training sessions.

Number of virtual training sessions.

Languages in which your organization can train:

Geographic locations your organization can cover:

whole state;

Twin Cities seven-county metropolitan area;

northern Minnesota;

western Minnesota;

southern Minnesota; or

other _____.

Are you able to provide a virtual option?

If so, what applications do you use?

How many people can you train at one time?

Our organization is available to train during:

first shift;

second shift; and

third shift.

If there are changes in your capacity, provide an explanation for the changes and, if necessary, your plan for carrying out the training.

Data policies

I am aware our organization has responsibilities with the data obtained through this process. I affirm that our data security is up to date.

Provide any additional information that should be known about your organization and its ability to provide quality training for nursing home workers.

Acknowledgement

I understand and accept that, according to Minnesota Statutes sections 181.211 through 181.217, and the rules promulgated thereunder, the Nursing Home Workforce Standards Board may deny, revoke, suspend or limit this certification if I knowingly and willfully made a false statement or provided false documentation in this application or am unable to carry out training in the manner dictated by the board. I declare all statements and documentation provided with this application are true and correct.

Applicant's signature

_____ (organization) _____ (job title) _____ contact information

Date (month/day/year)

DRAFT