Office Use Only
□ Paid _____
□ No Money Paid

KENTUCKY BOARD OF NURSING
DT Credentialing Program
312 Whittington Parkway Suite 300
Louisville, KY 40222
Phone: (502) 429-3300 or (800) 305-2042
Fax: (502) 429-3311
Website: kbn.ky.gov

APPLICATION FOR DIALYSIS TECHNICIAN TRAINING PROGRAM
Application fees are non-refundable

In accordance with 201 KAR 20:472-474 submit this completed application form and appended materials to the Kentucky Board of Nursing, DT Program. Print clearly using capital letters and black ink, and check the appropriate boxes.

SECTION 1: Application Type

□ Initial

□ Continued

□ Reinstatement

SECTION 2: Name/Address of Institution Offering DT Training Program

Facility**:** _____

Address: _____

City: _____ State: _____ Zip _____

Phone: _____ Fax: _____

Email: _____

SECTION 3: Name/Title of Program Administrator of DT Training Program

Last Name: _____ First Name: _____ MI: _____

Credentials: _____ License #: _____

Title: _____

SECTION 4: Anticipated Offering Date of the Program

For initial or reinstatement: When do you plan to offer this program?

_____

_____

_____

_____

SECTION 5: Program Documentation

Please attach the following documentation:

1. Name, position description, and qualifications of DT program administrator, including an updated CV/resume
2. Names and qualifications/description of faculty and clinical instructors, including an updated CV/resume – A current list of all faulty, including didactic, clinical and preceptors.
3. Course syllabus including curriculum, program outcomes, teaching methods and activities, method of evaluation, and course calendar
4. Trainee clinical practice requirements.
5. Length of program and tentative program presentation dates.
6. Completion requirements for the training program and clinical experience/preceptorship – Attach a sample document to record clinical experience/preceptorship.
7. Records retention plan.
8. Copy of certificate of program completion form.
9. Copy of continued approval certification from CMS or an accrediting body recognized by CMS, any correspondence and reports to and from the renal dialysis center, and results from site visits conducted by CMS and the plan of correction for any deficiencies.
10. If applying for continued approval, the training roster for the past two (2) years and the annual training program evaluation summary report.
11. If applying for reinstatement, the training roster and annual training program evaluation summary as applicable.

SECTION 6: Fees

Make check or money order payable to Kentucky Board of Nursing and enclose the payment with this form. The application fee must be for the exact amount and is non-refundable.

Section 7: Signature

Signature: _____ Date: _____

Office Use Only Program Code # _____ Approval Date: _____

Amount paid: ☐ _____ Date Paid _____