

Nurse Aide Training Program (NATP) Review Questionnaire

(Please Type)

Facility Name: _____

Facility Program Number: _____

Contact Person Name: _____

Email Address: _____

Facility Address: _____

Facility City/State/Zip Code: _____

County: _____

Administrator: _____

Director of Nurses: _____

Program Coordinator: _____

Staff Development Coordinator: _____

Instructors: _____

Review Period Dates: _____ to _____

of current trainees (in training) in class and/or clinical _____

of candidates that received a Certificate of Completion _____

certified (passed the state competency exam) _____

of candidate withdrawals _____

failed the NATP _____

of Retests _____

of Program Offerings _____

of current trainees on staff (Nursing Home Only) _____

Current copy of the Nurse Aide Program Manual on file (Yes or No) _____

Trainees received the Copy of the Georgia Nurse Aide Candidate Handbook (Yes or No) _____

Credentia In-Facility Test Site (Yes or No) _____ Credentia Regional Test Site (Yes or No) _____

Attestation statement: I attest that this information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission of material fact may jeopardize the status of this Georgia Nurse Aide Program.

Signature _____ Date _____