QUALITY CARE HEALTH FOUNDATION

2201 K Street, Sacramento, CA 95816
P.O. Box 537004, Sacramento, CA 95853-7004
Phone: (916) 441-6400 Ext. 210 or 211
Fax : (916) 446-4454

CAHF CHAPTER TRAINING MODULE REQUEST

PLEASE FAX OR MAIL TO QCHF

Fees are: **$ 100.00 if submitting a new request**
$ 45.00 if using a pre-approved class
Check Enclosed ☐
Deduct from Chapter Dues: ☐

Date of Request: ______________________ Date of Program: ______________________

New Program: ☐ (date of program must be at least 35 days away)
Pre-Approved Program: ☐

Title of Program: ______________________

Chapter Name: ______________________

Chapter Contact Person: ______________________

Phone Number: ______________________ Fax Number: ______________________

E-Mail Address: ______________________

Facility Name: ______________________

Facility Address: ______________________

Location of Program: (City & State) ______________________

Number of Hours Requested: _____ (Length of Program rounded to the nearest hour)

Indicate Mailing Preference: ☐ U.S. Mail ☐ E-Mail

CREDITS DESIRED: (Licensure boards make final approval on all categories of credits approved).

☐ **NAHP (BNHA)** ☐ **NHAP with/P** ☐ **BRN** ☐ **RCFE***

- **If applying for RCFE, please make sure your topic applies to RCFE (assisted living).**
- **If applying for RCFE, Please make sure your request is in the QCHF office 75 days prior to program date.**

FOUR QCHF OFFICE USE ONLY: **FEE PAID $** ______________ **CK.#** ______________
Processed By: ______________ **NHAP#**______________
Date Sent to Chapter: ______________ **BRN#**______________
Invoice Date: ______________ **RCFE#**______________

COURSE INFORMATION

Program Date: ______________________

Program Title: ______________________________

SPEAKER/INSTRUCTOR INFORMATION
(Must include resume or curriculum vitae)

PLEASE NOTE: All information must be complete for continuing education credit approval.

Instructor Name: ______________________________

Educational Credentials (degree and field) of speaker/instructor: ______________________________

If requesting RCFE's (Please include the following)
Social Security #: ______________ License #: ______________

Years of teaching experience: ______ Years in long term care: ________

BRIEF DESCRIPTION OF COURSE

____
____
____
____
____
____
____

OBJECTIVES
(e.g., At the completion of this program participants will be able to describe, identify, understand, list, evaluate, demonstrate, etc.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

AGENDA
(Must be completed in one hour increments)

First Hour: ______________________________

Second Hour: ______________________________

Third Hour: ______________________________

Fourth Hour: ______________________________