Ohio Board of Nursing www.nursing.ohio.gov
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

Dialysis Technician Training Program Re-Approval Application

Program Contact Information

Legal/Official Name of Program _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email Address _____

Name of organization providing program _____

Address **(If different from above)** _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email Address _____

Nurse Administrator Contact Information

Nurse Administrator **(Must be an Ohio Registered Nurse)** _____

Telephone Number _____ Fax Number _____ Email Address _____

Please provide the following information:

- How many classes will be provided per year? _____What is the expected average enrollment per class? _____
- Is clinical instruction provided at the above address? Yes ☐ No ☐
- **Provide information below for all clinical site(s) used: Attach a separate sheets of paper if needed to list additional facilities.**

Name of Clinical Site _____

Contact Person _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email Address _____

Name of Clinical Site _____

Contact Person _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____ Email Address _____

Verification of Rule Compliance:

Indicate yes or no below that the dialysis technician training program meets and maintains the following requirements:

	YES	NO
The training program consists of not less than 100 clock hours of faculty-interactive theoretical instruction, and not less than 220 clock hours of supervised clinical experience, and meets content required by Rule 4723-23-08 (A), OAC.	☐	☐
The program is administered by a registered nurse who meets the qualifications established in Rule 4723-23-08(B), OAC.	☐	☐
The nurse administrator has assured that the governing body has established and implemented written policies required by Rule 4723-23-08(E),and the administrator has implemented the policies as written as requied by Rule 4723-23-08(D), OAC.	☐	☐
The registered nurse administrator utilizes other health care professionals to assist in conducting classroom and clinical portions of the program in accordance with the health care professional's educational background and applicable scope of practice as required in Rule 4723-23-08(C), OAC.	☐	☐
The program has adopted and implemented all policies required by Rule 4723-23-08(E), OAC.	☐	☐

I attest that the above information represents accurately the information on file for the specified dialysis technician training program.

Signature _____ Date _____

Registered Nurse Administrator

Please submit the application, documents and credit card authorization form in the amount of $300 to the Board. Incomplete submissions will NOT be processed.

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Credit Card Authorization Form

Card Holder Name: _____

Address Associated with Credit Card: _____

_____

Type of Card: ☐ Master Card ☐ Visa ☐ Discover

Card Number: _____

Card Expiration Date: _____

CVV _____

Payment Amount: _____

Reason for Payment (Please Check Box):

☐ Disqualifying Determination Request
Email this form to: disqualifying-offense-requests@nursing.ohio.gov

☐ Community Health Worker Training Program
Email this form to: fiscal@nursing.ohio.gov

☐ Dialysis Technician Training Program
Email this form to: fiscal@nursing.ohio.gov

☐ Medication Aide Training Program
Email this form to: fiscal@nursing.ohio.gov

☐ OBN Approver of CE
Email this form to: fiscal@nursing.ohio.gov

Your signature on this form authorizes use of the credit card shown for the amount listed to pay fees to the Ohio Board of Nursing.

Cardholder's Signature: _____

Date: _____