|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-00385 (02/11) | | | | | **STATE OF WISCONSIN** | | | | | | | |
| **NURSE AIDE TRAINING**  **STUDENT WAIVER REQUEST** | | | | | | | | | | | | |
| * The purpose of this form is to provide the Division of Quality Assurance (DQA) with information regarding a student’s request to complete their training beyond the enrolled course completion date. This form should be used when a student has started a course but is unable to complete the training by the end of the specific course. Examples would include excessive absences, medical or personal issue. * If you have any questions about the completion of this form, please contact the Office of Caregiver Quality at (608) 261-8328. * Submit this completed form to: Wisconsin Nurse Aide Training Consultant   Office of Caregiver Quality  P.O. Box 2969  Madison, WI 53701-2969  FAX: 608-264-6340   * **Attach doctor’s note, if applicable.** | | | | | | | | | | | | |
| **PROGRAM INFORMATION** | | | | | | | | | | | | |
| Name – Program | | | | | | | | | | | | Program Number |
| Address – Street or P.O. Box | | | | | City | | | | State | | | Zip Code |
| Name – Contact Person | | Telephone Number | | | | | E-mail Address | | | | | |
| **STUDENT INFORMATION** | | | | | | | | | | | | |
| Name – Student | | | | | | | | Social Security Number | | | | |
| **TRAINING INFORMATION** | | | | | | | | | | | | |
| Class Start Date | **Class Dates and Hours Missed** | | | | | | | | | |  | |
| **Dates Missed** | | | | | **Hours Missed** | | | | |
| Class End Date |  | | | | |  | | | | |
|  | | | | |  | | | | |
|  |  | | | | |  | | | | |
|  | | | | |  | | | | |
| **TOTAL HOURS MISSED** | | | | |  | | | | |
| **PLAN FOR MAKE-UP** | | | | | | | | | | | | |
| Date(s) of Make-up Time | | | | | | | | | | | | |
| Reintegration Plan *(if make-up is not immediate)* | | | | | | | | | | | | |
| Comments | | | | | | | | | | | | |
| **DHS USE ONLY** | | | | | | | | | | | | |
| **Approved** – Program must be completed by: | | |  | | | | | | | | | |
| **Approved Pending** – Information Needed | | |  | | | | | | | | | |
| **Denied** | | | | | | | | | | | | |
| Reason for Denial | | | | | | | | | | | | |
| **SIGNATURE** – Reviewer | | | | Title | | | | | | Date Signed | | |