



## LETTER OF INTENT TO SUBMIT APPLICATION for INITIAL APPROVAL of NEW SCHOOL OR PROGRAM – Vocational Nursing

This completed form along with all written statements and documentation required by this form is in accordance with section 2526 of Title 16 of the California Code of Regulations (CCR) must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) to begin the approval process for a new school or program of vocational nursing. The information requested on this form is mandatory pursuant to Business and Professions Code section 2881.2 and Title 16 CCR section 2526. The information provided on this form and in written statements will be used to identify the proposed school or program and to calculate an estimated wait time until active assignment to a nursing education consultant. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.

<b>Program Type:</b>	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time
<input type="checkbox"/> Community College	<input type="checkbox"/> Adult School	<input type="checkbox"/> Regional Occupational Program
<input type="checkbox"/> Private	<input type="checkbox"/> Hospital-Based	<input type="checkbox"/> Other

**Proposed School or Program Name**

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**Mailing Address:**

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**Name of Owner of Proposed School or Program (Attach additional sheets as necessary):**

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**Program Director's Name:**

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**Program Director's Office Address:**

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**Direct Phone #:**

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**Email Address:**

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**Signature of Program Director:**

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**Date:**

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**Printed Name:**

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Programs should email the Board immediately at [BVNPT.Education@dca.ca.gov](mailto:BVNPT.Education@dca.ca.gov) or [BVNPT.Proposed.Programs@dca.ca.gov](mailto:BVNPT.Proposed.Programs@dca.ca.gov) if there are any changes in contact information. Failure to provide updated contact information may delay processing if the Board cannot reach the school or program.

Please proceed to the next page for further instruction on how to complete this form.

Written narrative statements and documentation must be attached to this form and submitted to the Board to begin the approval process. The institution shall provide separate responses, including the provision of any applicable documents, to each item requested below. The institution shall clearly identify their responses by placing the name of the institution at the top of each page that is provided and then using a simple naming convention that, at a minimum, links each response to the number and subject matter of the request listed below, and provides the date of the response or document (e.g., "1. Philosophy of the program. 2/2/2022").

### **Section 1: Philosophy of Program:**

Attach a document that outlines the program's values, ethics, and beliefs ("philosophy"). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning.

### **Section 2: Conceptual Framework:**

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program (as described in section 1).

### **Section 3: Terminal Objectives:**

Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable criteria regarding the student's successful completion of progressive components of the program, e.g., completion of courses, terms, or semesters. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing of the examination set forth in section 2510, and being able to perform as a competent entry level vocational nurse.

### **Section 4: Feasibility Narrative:**

Attach a description of the type of school or program being proposed, the total cost to the student to complete the program (including tuition, all fees, uniforms, materials, etc.) the intended start date, and the projected size of the first class.

### **Section 5: Title and General Description of Each Course:**

Attach a list of the name(s) of each course and provide a corresponding general course description. The course description shall describe the subject matter of the course and the educational objectives of each course.

### **Section 6: Clinical Facility Placement List:**

Attach a list of the clinical facilities that are intended to be utilized for learning experiences. The institution shall submit a completed "Intent for Clinical Facility Placement," which is attached below, for each health care facility that agrees to provide clinical placement for students of the proposed school or program.

### **Section 7: Student Services List:**

Attach a list of resources for provision of counseling and tutoring services for students and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address).

**Section 8: Geographic Narrative:**

Attach a description of the geographic area and community to be served by the proposed school or program (e.g., demographics, numbers of health facilities in the area in need of nursing, or potential future growth of the community).

Please proceed to the next page to complete the form listed below.



**INTENT FOR CLINICAL FACILITY PLACEMENT**

**Program Name:** \_\_\_\_\_ **Type:**  **VN**  **PT**

**Program Campus Location:** \_\_\_\_\_

**Clinical Experience Address:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Facility Administrator/Director Name:** \_\_\_\_\_

**Name/Title of Person Responsible for Student Placement:** \_\_\_\_\_

**Facility Contact Person:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Projected Term/Semester for Clinical Site:** \_\_\_\_\_

**Projected Content Area(s):** \_\_\_\_\_

**Projected Number of Students per Rotation:** \_\_\_\_\_

**Facility Director's Printed Name:** \_\_\_\_\_

**Facility Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director's Printed Name:** \_\_\_\_\_

**Program Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This completed form must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) to begin the approval process for a new school or program. The information requested on this form is mandatory pursuant to Title 16, California Code of Regulations sections 2526 or 2581, as applicable. The information provided on this form will be used to identify the proposed school or program and to calculate an estimated wait time until active assignment to a nursing education consultant. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.



## LETTER OF INTENT TO SUBMIT APPLICATION for INITIAL APPROVAL of NEW SCHOOL OR PROGRAM – Psychiatric Technician

This completed form along with all written statements and documentation required by this form in accordance with section 2581 of Title 16 of the California Code of Regulations (CCR) must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) to begin the approval process for a new psychiatric technician school or program. The information requested on this form is mandatory pursuant to Business and Professions Code section 4531.1 and Title 16 CCR section 2581. The information provided on this form and in written statements will be used to identify the proposed school or program and to calculate an estimated wait time until active assignment to a nursing education consultant. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.

**Program Type:**             Full Time             Part Time  
 Community College     Adult School         Regional Occupational Program  
 Private                     Hospital-Based      Other

**Proposed School or Program Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Name of Owner of Proposed School or Program (Attach additional sheets as necessary):** \_\_\_\_\_

**Program Director's Name:** \_\_\_\_\_

**Program Director's Office Address:** \_\_\_\_\_

**Direct Phone #:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Signature of Program Director:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

Programs should email the Board immediately at [BVNPT.Education@dca.ca.gov](mailto:BVNPT.Education@dca.ca.gov) or [BVNPT.Proposed.Programs@dca.ca.gov](mailto:BVNPT.Proposed.Programs@dca.ca.gov) if there are any changes in contact information. Failure to provide updated contact information may delay processing if the Board cannot reach the school or program.

Please proceed to the next page for further instruction on how to complete this form.

Written narrative statements and documentation must be attached to this form and submitted to the Board to begin the approval process. The institution shall provide separate responses, including the provision of any applicable documents, to each item requested below. The institution shall clearly identify their responses by placing the name of the institution at the top of each page that is provided and then using a simple naming convention that, at a minimum, links each response to the number and subject matter of the request listed below, and provides the date of the response or document (e.g., "1. Philosophy of the program. 2/2/2022").

### **Section 1: Philosophy of Program:**

Attach a document that outlines the program's values, ethics, and beliefs ("philosophy"). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning.

### **Section 2: Conceptual Framework:**

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program (as described in section 1).

### **Section 3: Terminal Objectives:**

Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable statements regarding the student's successful completion of progressive components of the program, e.g., completion of courses, terms, semesters. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing examinations as described in section 2570, and being able to perform as a competent entry level psychiatric technician.

### **Section 4: Feasibility Narrative:**

Attach a description of the type of school or program being proposed, the total cost to the student to complete the program (including tuition, all fees, uniforms, materials, etc.), the intended start date, and the projected size of the first class.

### **Section 5: Title and General Description of Each Course:**

Attach a list of the name(s) of each course and provide a corresponding general course description. The course description shall describe the subject matter of the course and the educational objectives of each course.

### **Section 6: Clinical Facility Placement List:**

Attach a list of the clinical facilities that are intended to be utilized for learning experiences. The institution shall submit a completed "Intent for Clinical Facility Placement," which is attached below, for each health care facility that agrees to provide clinical placement for students of the proposed school or program.

### **Section 7: Student Services List:**

Attach a list of resources for provision of counseling and tutoring services for students and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address).

**Section 8: Geographic Narrative:**

Attach a description of the geographic area and community to be served by the proposed school or program (e.g., demographics, numbers of health facilities in the area in need of psychiatric technician services, or potential future growth of the community).

Please proceed to the next page to complete the form listed below.



**INTENT FOR CLINICAL FACILITY PLACEMENT**

**Program Name:** \_\_\_\_\_ **Type:**  **VN**  **PT**

**Program Campus Location:** \_\_\_\_\_

**Clinical Experience Address:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Facility Administrator/Director Name:** \_\_\_\_\_

**Name/Title of Person Responsible for Student Placement:** \_\_\_\_\_

**Facility Contact Person:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Projected Term/Semester for Clinical Site:** \_\_\_\_\_

**Projected Content Area(s):** \_\_\_\_\_

**Projected Number of Students per Rotation:** \_\_\_\_\_

**Facility Director's Printed Name:** \_\_\_\_\_

**Facility Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director's Printed Name:** \_\_\_\_\_

**Program Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**APPLICATION FOR APPROVAL OF NEW SCHOOL OR PROGRAM  
OF VOCATIONAL NURSING (“Program”)**

(California Business and Professions Code (BPC) Sections 2880-2884 and Title 16,  
California Code of Regulations (16 CCR) Sections ~~2525~~, 2526, 2529, 2530, 2532, 2533,  
2534, and California Education Code Section 94899)

**(\$5,000.00 Non Refundable Initial Application Fee)**

This application must be completed in its entirety or the application may be rejected as incomplete. Attach additional sheets if necessary. Any material misrepresentation of any information on the application is grounds for denial or subsequent removal of the approval.

Under Business and Professions Code (BPC) sections 31 and 494.5, the California Department of Tax and Fee Administration (CDTFA) and the Franchise Tax Board (FTB) may share taxpayer information with the Board. You are required to pay your state tax obligation. This application may be denied or your approval may be suspended if you have a state tax obligation and the state tax obligation is not paid and your name appears on either the CDTFA or FTB certified list of top 500 tax delinquencies.

**Section 1: Program Information**

Proposed Program Name: \_\_\_\_\_

Physical Address of Proposed Program:  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address of Proposed Program (if different from above):  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Website Address: \_\_\_\_\_

Program Type:       Full Time       Part Time  
 Community College       Adult School       Regional Occupational Program  
 Private       Hospital-Based       Other: \_\_\_\_\_

Program Director’s Name: \_\_\_\_\_

Program Director’s Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Direct Phone #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Affiliate Campus Only:** If this program is affiliated with an approved school or program, provide all of the following information. "Affiliated" means your school or program has a formal collaborative agreement with an approved school or program, as defined in BPC section 2881, that controls its academic policies and curriculum, and where your school or program agrees to utilize the policies and curriculum of the approved school or program.

Affiliate Campus Name: \_\_\_\_\_

Affiliate Campus Address: \_\_\_\_\_

Affiliate Campus Contact Name: \_\_\_\_\_

Affiliate Campus Contact Telephone Number: \_\_\_\_\_

Affiliate Campus Contact Email Address: \_\_\_\_\_

**Required Documentation:** ~~Provide with this application~~ Attach a signed and dated copy of the formal collaborative agreement between your program and an approved school or program that is in good standing, showing your program agrees to utilize the curriculum and policies of the approved school or program. "In good standing" means the approved school or program has a current and active approval with the Board and no provisional approval.

**Section 2: Contact Person for this Application:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Section 3: Applicant/Ownership Information:**

Full Legal Name of Applicant/Owner of Program : \_\_\_\_\_

Address of Applicant: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

For corporation or LLC applicants, list the following information for each of the principal individuals who are the officer(s), managers or officials of the entity who are responsible for the operations or management of the corporation or LLC.

Individual 1:

Name	Title
_____	_____
Address	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security Number/ITIN	E-mail address
_____	_____

Individual 2:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

Individual 3:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

**Notice:** Collection of the SSN, ITIN, and FEIN is authorized by BPC sections 30 and 31. SSNs, ITINs, and FEINs are used exclusively for the purpose of tax enforcement, and compliance with any judgment or order for family support in accordance with Family Code section 17520. If you fail to disclose your SSN, ITIN, or FEIN, your application will not be processed, and you will be reported to the Franchise Tax Board; they may assess a \$100 penalty against you.

**Section 4: Form of Business Organization:**

The applicant will operate the program as a (check only one):

(Note: For corporations and Limited Liability Companies (LLC), please ~~provide~~ attach a current and active California Secretary of State corporate or LLC entity registration number

below. For questions regarding registration requirements, please contact the California Secretary of State; their information is available at [www.sos.ca.gov](http://www.sos.ca.gov).)

- Individually Owned/Sole Proprietorship. Social Security No. \_\_\_\_\_
- General Partnership FEIN # \_\_\_\_\_
- Limited Partnership FEIN # \_\_\_\_\_
- Corporation. SOS Reg. #. \_\_\_\_\_
- Limited Liability Company. SOS Reg. #. \_\_\_\_\_
- Government Owned Program

(For corporations, submit the Articles of Incorporation, for an LLC, submit the Articles of Organization, and for partnerships, ~~provide~~ attach a current executed partnership agreement for the applicant business with this application.)

### **Section 5: Disciplinary History:**

Within the preceding 7 years from the date of this application, has the applicant ever had a school or program approval and/or any other license suspended, revoked, placed on probation, or had other disciplinary action, including public reproof or reprimand, taken against a license the applicant has held by a state licensing board in or outside of California?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, attach a statement to this application providing all of the following: (1) the name of the state licensing board that imposed the discipline, (2) the type of discipline imposed, (3) the effective dates of discipline; and (4) a description of the violations found by the state licensing board.

### **Section 6: Organization and Management:**

~~Provide~~ attach an organizational chart which reflects the program's current status, identifies all positions within the program and clearly distinguishes lines of accountability and communication.

Document is attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Section 7: Geographic Narrative:**

Attach a description of the geographic area and community to be served by the proposed school or program (e.g, demographics, numbers of health facilities in the area in need of nursing, or potential future growth of the community). If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document is attached: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ No Changes to Letter of Intent

### **Section 8: Feasibility Narrative:**

Attach a description of the type of school or program being proposed, the total cost to the student to complete the program (including tuition, all fees, uniforms, materials, etc.) the intended start date, and the projected size of the first class. If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document is attached:  Yes  No  No Changes to Letter of Intent

**Section 9: Philosophy of Program:**

Attach a document that outlines the program’s values, ethics, and beliefs (“philosophy”). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning. If this information has not changed since submission of the applicant’s Letter of Intent to the Board, write “No Changes to Letter of Intent” here.

Document is attached:  Yes  No  No Changes to Letter of Intent

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**Section 10: Conceptual Framework:**

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program (as described in Section 9). If this information has not changed since submission of the applicant’s Letter of Intent to the Board, write “No Changes to Letter of Intent” here.

Document is attached:  Yes  No  No Changes to Letter of Intent

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**Section 11: Clinical Facility Placement:**

Attach a completed *Clinical Facility Verification Form*, Form 55M-3A (New 04/2022), for each health care facility. This form must be completed for each health care facility that agrees to provide clinical placement for students of the proposed program. 16 CCR section 2534 requires programs to have clinical facilities adequate as to number, type, and variety of patients treated, and to provide clinical experience for all students in the areas specified by 16 CCR section 2533.

Document is attached:  Yes  No

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**Section 12: Terminal Objectives:**

Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable criteria regarding the student’s successful completion of progressive components of the program, i.e. courses, terms, semester. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing of the examination as set forth in section 2510, and being able to perform as a competent entry level vocational nurse. If this information has not changed since submission of the applicant’s Letter of Intent to the Board, write “No Changes to Letter of Intent” here.

Document is attached:  Yes  No  No Changes to Letter of Intent

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**Section 13: Evaluation methodology for curriculum:**

Attach an explanation of the process that identifies the method(s) by which the curriculum is evaluated regularly.

Document is attached:  Yes  No

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**Section 14: Attach course outlines for each course:**

A course outline is a document that reflects the outline and objectives for specific competencies related to essential elements within separate courses or terms. Course outlines reflect entry-level competencies within the VN scope of practice, theory and correlated clinical experience, and progressive mastery of subject matter.

Document(s) attached:  Yes  No

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**Section 15: Instructional plan:**

Attach the instructional plan and program hours for the proposed program using Forms 55M-2E and 55M-2W as described below. An instructional plan is a document that correlates theory and clinical content and hours on a weekly basis and provides an overview of the teaching schedule; the document must show the program's commitment to curriculum in which theory hours precede clinical hours. The following must be completed and submitted with this application: *Vocational Nursing or Psychiatric Technician Program Curriculum Content - Instructional Plan Form 55M-2W (New 04/2022)* and *Summary of Instructional Plan Program Hours Form 55M-2E (New 04/2022)* to meet the requirements of this section.

Document is attached:  Yes  No

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**Section 16: Daily lesson plans:**

Attach copies of proposed daily lesson plans for the first two weeks of each course of instruction. A daily lesson plan is a document that correlates the theory and practice for each instruction day for the instructor to follow.

Document is attached:  Yes  No

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**Section 17: Faculty meeting methodology:**

Attach a document describing the faculty meeting methodology for the program, including a statement of the frequency of faculty meetings, and confirms that any minutes from those meetings shall be available to the Board's representative.

Document is attached:  Yes  No

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**Section 18: Verification of Faculty Qualifications:**

A proposed program must submit qualifications of the proposed faculty members for approval by the Board prior to employment as required by 16 CCR 2529. Attach a completed "Verification of Faculty Qualification" Form 55M-10 (New 04/2022) for each proposed faculty member with this application.

Document(s) attached:  Yes  No

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**Section 19: Evaluation methodology for clinical facilities:**

Attach an explanation of the process for evaluating clinical facilities, including identification of the tool(s) used by the program to evaluate the clinical facilities, e.g., surveys, forms, checklists.

Document(s) attached:  Yes  No

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**Section 20: Admission criteria:**

Attach a document listing the ~~Provide an explanation of~~ requirements for a student's admission to the school or program.

Document is attached:  Yes  No

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**Section 21: Screening and selection criteria:**

Attach ~~Provide~~ a document listing and explaining the criteria for selection of program candidates if there are more qualified applicants than available seats within an upcoming cohort. "Cohort" or "class" means a group of students intended for enrollment in an approved school or program of vocational nursing.

Document is attached:  Yes  No

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**Section 22: Student Services List:**

Attach ~~Provide~~ a list of resources for provision of counseling and tutoring services for students and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address). If this information has not changed since submission of the applicant's Letter of Intent to the Board, check ~~write~~ "No Changes to Letter of Intent" here.

Document is attached:  Yes  No  No Changes to Letter of Intent

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**Section 23: Number of students:**

Identify the proposed number of students for initial cohort: \_\_\_\_\_. If the school or program plans to accept alternate students, attach provide a document that describes the policy for admission of alternate students including:

- The criteria for accepting alternate students; and
- The process used if all alternates are not needed to fill class at the beginning of clinical experience.

Note the following per 16 CCR 2526:

- ❖ A school or program may admit alternate students in each new class to replace students who may drop out.
- ❖ The number of alternate students admitted may not exceed 10% of the school’s approved number of students per class.
- ❖ Prior to admission, alternate students must be informed in writing of their alternate status and that they may be dropped from the program.
- ❖ Alternate students may participate in classes until the commencement of scheduled clinical experience at approved clinical facilities.
- ❖ Upon commencement of clinical experience at approved clinical facilities, the actual number of students in the class may not exceed the number of students approved by the Board for that particular class.

Note: The number of students a school or program will be allowed to admit to its initial class is based on the program director’s request and demonstrated available resources per 16 CCR 2530 and determined after all program documentation is submitted.

Document(s) attached:  Yes  No

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**Section 24: Evaluation methodology for student progress:**

Attach Provide a statement that describes the elements used for evaluation of student progress. (May include grading policy.) Explain the process or identify the tool used by the instructor and/or preceptor (if applicable) to evaluate student progress in mastering the course and program objectives. The written narrative must identify objectives or criteria for measuring student progress and the methods for evaluation, action, follow-up, and documentation of outcomes. This methodology may include quizzes, testing, mid-term evaluations etc. for early identification of at-risk students.

Document is attached:  Yes  No

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**Section 25: Attendance policy:**

Attach Provide a written narrative describing the school or program’s attendance policy in compliance with 16 CCR 2530(h), which must include:

- ❖ Attendance criteria; and,
- ❖ Make-up criteria and forms (if applicable), which specify appropriate methods for make-up of theory and clinical objectives.



Document is attached:  Yes  No

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**Section 26: Grievance policy:**

Attach ~~Provide~~ a description of the program's grievance policy and for providing notice of the policy as required by 16 CCR 2530 (j)(3).

Document is attached:  Yes  No

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**Section 27: Required Notices:**

Attach ~~Provide~~ a description of the process to advise students about their rights to contact the Board of program concerns, the program's process for credit granting for previous education and experience, and the program's Board-approved clinical facilities as required by 16 CCR 2530.

Document is attached:  Yes  No

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**Section 28: Credit Granting:**

Attach ~~Provide~~ a description of the program's policy for giving credit toward the curriculum requirements, a determination of the curriculum area to which credit is applied, and justification for the credit applied, including how the program plans to comply with requirements for transfer credit for related previous education completed within the last five years in compliance with 16 CCR 2535.

Document is attached:  Yes  No

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**Section 29: Remediation:**

Attach ~~Provide~~ a description of how the program evaluates student performance to determine the need for remediation, including the program's remediation criteria/policy and actions taken if the student does not fulfill the requirements.

Document is attached:  Yes  No

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**Section 30: Program Resources:**

Attach ~~Provide~~ a detailed description of the program resources, including: classroom(s), library and other learning resources (e.g., texts, videos, software, online materials, and other materials used to assist students to meet the expectations for learning), support services (e.g, course and career counseling, student financial aid advisors), physical space, skills laboratory and equipment to achieve the program's objectives. The program may also submit pictures of the campus and resources to support the included description. (16 CCR 2530 (a))

Document is attached:  Yes  No

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**Section 31: Eligibility for Expedited Review of Application (for Individual Owners/Sole Proprietorships Only)**

A. Are you serving in, or have you previously served in, the United States military? (BPC section 114.5)

- Yes  
 No

B. If you answered “yes” above, are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces? (BPC section 115.4)

- Yes  
 No

If you checked “Yes” for this question, please attach ~~provide~~ the following documentation to receive expedited review: evidence of your current military duty (copy of your military orders) or your previous military service (copy of your DD 214 – Certificate of Release or Discharge from Active Duty).

C. Do any of the following statements apply to you:

- Yes  
 No
- You were admitted to the United States as a refugee pursuant to section 1157 of Title 8 of the United States Code,
  - You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of Title 8 of the United States Code; or,
  - You have a special immigrant visa and were granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters of those who worked for or on behalf of the United States government].

D. If you selected “yes,” you must attach evidence of your status as a refugee, asylee, or special immigrant visa holder as provided below. Failure to do so may result in application processing delays. “Evidence” shall include:

- Form I-94, arrival/departure record, with an admission class code such as “re” (refugee) or “ay” (asylee) or other information designating the person a refugee or asylee.
- Special Immigrant Visa that includes the “si” or “sq” designation.
- Permanent resident card (Form I-551), commonly known as a “green card,” with a category designation indicating that the person was admitted as a refugee or asylee.

- An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Business and Professions Code section 135.4.

**I declare under penalty of perjury under the laws of the State of California that I am authorized to sign this application on behalf of the applicant, that I have read this application and the information provided herein along with any accompanying documents, and that the foregoing and all attachments are true and correct.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Applicant or Authorized Representative: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

ZIP \_\_\_\_\_

### **NOTICE OF COLLECTION OF PERSONAL INFORMATION**

The information provided in this application will be used by the Board of Vocational Nursing and Psychiatric Technicians (Board) to determine whether the applicant institution qualifies for approval. Unless otherwise specified, all information requested on this application is mandatory. Sections 30, 31, 494.5, and 2881.2 of the California Business and Professions Code and Title 16 CCR section 2526 authorize the collection of this information. Failure to provide any of the required information is grounds for rejection of the application as being incomplete. Information provided may be transferred to the Department of Justice, a District Attorney, a City Attorney, the Franchise Tax Board, the California Department of Tax and Fee Administration, or to another government agency as may be necessary to permit the Board, or the transferee agency, to perform its statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. Each individual or applicant has the right to review their file, except as otherwise provided by the California Information Practices Act. Social security numbers (SSN) and individual taxpayer identification numbers (ITIN) are not considered public records. However, other information provided on this form may be disclosed to a member of the public, upon request, under the California Public Records Act. The Executive Officer of the Board is responsible for maintaining the information in this form, and may be contacted at 2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833, telephone number 916-263-7843 regarding questions about this notice or access to records.





**APPLICATION FOR APPROVAL OF A NEW PSYCHIATRIC TECHNICIAN  
SCHOOL OR PROGRAM  
("Program")**

(California Business and Professions Code (BPC) Sections 453-4532 and Title 16,  
California Code of Regulations (16 CCR) Sections ~~2580~~, 2581, 2584, 2585, 2585.1, 2586,  
2587,  
2588, 2588.1, and California Education Code Section 94899)

**(\$5,000.00 Non Refundable Initial Application Fee)**

This application must be completed in its entirety or the application may be rejected as incomplete. Attach additional sheets if necessary. Any material misrepresentation of any information on the application is grounds for denial or subsequent removal of the approval.

Under Business and Professions Code (BPC) sections 31 and 494.5, the California Department of Tax and Fee Administration (CDTFA) and the Franchise Tax Board (FTB) may share taxpayer information with the Board. You are required to pay your state tax obligation. This application may be denied or your approval may be suspended if you have a state tax obligation and the state tax obligation is not paid and your name appears on either the CDTFA or FTB certified list of top 500 tax delinquencies

**Section 1: Program Information**

Proposed Program Name: \_\_\_\_\_

Physical Address of Proposed Program: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address of Proposed Program (if different from above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Website Address: \_\_\_\_\_

Program Type:       Full Time       Part Time  
  
 Community College       Adult School       Regional Occupational Program



**Section 3: Applicant/Ownership Information:**

Full Legal Name of Applicant/Owner of Program: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_ City: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

For corporation or LLC applicants, list the following information for each of the principal individuals who are the officer(s), managers or officials of the entity who are responsible for the operations or management of the corporation or LLC.

Individual 1:

Name	Title
_____	_____
Address	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security Number/ITIN	E-mail address
_____	_____

Individual 2:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

Individual 3:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

**Notice:** Collection of the SSN, ITIN, and FEIN is authorized by BPC sections 30 and 31. SSNs, ITINs, and FEINs are used exclusively for the purpose of tax enforcement, and compliance with any judgment or order for family support in accordance with Family Code section 17520. If you fail to disclose your SSN, ITIN, or FEIN, your application will

not be processed, and you will be reported to the Franchise Tax Board; they may assess a \$100 penalty against you.

#### Section 4: Form of Business Organization:

The applicant will operate the program as a (check only one):

(**Note:** For corporations and Limited Liability Companies (LLC), please provide attach a current and active California Secretary of State corporate or LLC entity registration number below. For questions regarding registration requirements, please contact the California Secretary of State; their information is available at [www.sos.ca.gov](http://www.sos.ca.gov).)

- Individually Owned/Sole Proprietorship. Social Security No. \_\_\_\_\_
- General Partnership FEIN # \_\_\_\_\_
- Limited Partnership FEIN # \_\_\_\_\_
- Corporation. SOS Reg. #. \_\_\_\_\_
- Limited Liability Company. SOS Reg. #. \_\_\_\_\_
- Government Owned Program

For corporations, submit the Articles of Incorporation, for an LLC, submit the Articles of Organization, and for partnerships, provide attach a current executed partnership agreement for the applicant business with this application.

#### Section 5: Disciplinary History:

Within the preceding 7 years from the date of this application, has the applicant ever had a school or program approval and/or any other license suspended, revoked, placed on probation, or had other disciplinary action, including public reproof or reprimand, taken against a license the applicant has held by a state licensing board in or outside of California?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, attach a statement to this application providing all of the following: (1) the name of the state licensing board that imposed the discipline, (2) the type of discipline imposed, (3) the effective dates of discipline; and (4) a description of the violations found by the state licensing board.

#### Section 6: Organization and Management:

~~Provide~~ Attach an organizational chart which reflects the program's current status, identifies all positions within the program and clearly distinguishes lines of accountability and communication.

Document attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

#### Section 7: Geographic Narrative:

Attach a description of the geographic area and community to be served by the proposed school or program (e.g, demographics, numbers of health facilities in the area in need of psychiatric technicians, or potential future growth of the community). If this information has not changed since submission of the applicant's Letter of Intent to the Board, please write "No Changes to Letter of Intent" here.



Document attached:  Yes  No

**Section 8: Feasibility Narrative:**

Attach a description of the type of school or program being proposed, the total cost to the student to complete the program (including tuition, all fees, uniforms, materials, etc.) the intended start date, and the projected size of the first class. If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document attached:  Yes  No  No Changes to Letter of Intent

**Section 9: Philosophy of Program:**

Attach a document that outlines the program's values, ethics, and beliefs ("philosophy"). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning. If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document attached:  Yes  No  No Changes to Letter of Intent

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**Section 10: Conceptual Framework:**

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program (as described in Section 9). If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document attached:  Yes  No  No Changes to Letter of Intent

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**Section 11: Clinical Facility Placement:**

Attach a completed *Clinical Facility Verification Form*, Form 56M-3A (New 04/2022), for each health care facility. This form must be completed for each health care facility that agrees to provide clinical placement for students of the proposed program. 16 CCR section 2588 requires programs to have clinical facilities adequate as to number, type, and variety of patients treated, and to provide clinical experience for all students in the areas specified by 16 CCR section 2587.

Document attached:  Yes  No

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**Section 12: Terminal Objectives:**

Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable criteria regarding the student's

successful completion of progressive components of the program, i.e. courses, terms, semester. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing of examinations as set forth in section 2570, and being able to perform as a competent entry level psychiatric technician. If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document attached:  Yes  No  No Changes to Letter of Intent

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**Section 13: Evaluation methodology for curriculum:**

Attach an explanation of the process that identifies the method(s) by which the curriculum is evaluated regularly.

Document attached:  Yes  No

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**Section 14: Attach course outlines for each course:**

Attach a course outline, a document that reflects the outline and objectives for specific competencies related to essential elements within separate courses or terms. Course outlines reflect entry-level competencies within the PT scope of practice, theory and correlated clinical experience, and progressive mastery of subject matter.

Document(s) attached:  Yes  No

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**Section 15: Instructional plan:**

Attach the instructional plan and program hours for the proposed program using Forms 55M-2W and 56M-2E as described below. An instructional plan is a document that correlates theory and clinical content and hours on a weekly basis and provides an overview of the teaching schedule; the document must show the program's commitment to curriculum in which theory hours precede clinical hours. The following must be completed and submitted with this application: *Vocational Nursing or Psychiatric Technician Program Curriculum Content - Instructional Plan* Form 55M-2W (New 04/2022) and *Summary of Program Hours Psychiatric Technician* Form 56M-2E (New 04/2022) to meet the requirements of this section. Course outlines reflect entry-level competencies within the PT scope of practice, theory and correlated clinical experience, and progressive mastery of subject matter.

Document attached:  Yes  No

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**Section 16: Daily lesson plans:**

Attach copies of proposed daily lesson plans for the first two weeks of each course of instruction. A daily lesson plan is a document that correlates the theory and practice for each instruction day for the instructor to follow.

Document attached:  Yes  No

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**Section 17: Faculty meeting methodology:**

Attach a document describing the faculty meeting methodology for the program, including a statement of the frequency of faculty meetings, and confirms that any minutes from those meetings shall be available to the Board's representative.

Document attached:  Yes  No

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**Section 18: Verification of Faculty Qualifications:**

Submit qualifications of the proposed faculty members for approval by the Board prior to employment as required by 16 CCR 2584. Attach a completed *Verification of Faculty Qualification* Form 55M-10 (New 04/2022) for each proposed faculty member with this application.

Document(s) attached:  Yes  No

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**Section 19: Evaluation methodology for clinical facilities:**

Attach an explanation of the process for evaluating clinical facilities, including identification of the tool(s) used by the program to evaluate the clinical facilities), e.g., surveys, forms, checklists.

Document(s) attached:  Yes  No

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**Section 20: Admission criteria:**

~~Attach a document listing the~~ Provide an explanation of requirements for a student's admission to the school or program.

Document attached:  Yes  No

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**Section 21: Screening and selection criteria:**

~~Attach Provide~~ a document listing and explaining the criteria for selection of program candidates if there are more qualified applicants than available seats within an upcoming cohort. "Cohort" or "class" means a group of students intended for enrollment in an approved school or program of vocationalnursing.

Document attached:  Yes  No

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**Section 22: Student Services List:**

~~Attach Provide~~ a list of resources for provision of counseling and tutoring services for students

and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address). If this information has not changed since submission of the applicant's Letter of Intent to the Board, write "No Changes to Letter of Intent" here.

Document attached:  Yes  No  No Changes to Letter of Intent

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**Section 23: Number of students:**

Identify the proposed number of students for initial cohort: \_\_\_\_\_. If the school or program plans to accept alternate students, ~~attach~~ provide a document that describes the policy for admission of alternate students including:

- The criteria for accepting alternate students; and
- The process used if all alternates are not needed to fill class at the beginning of clinical experience.

Note the following per 16 CCR 2581:

- ❖ A school or program may admit alternate students in each new class to replace students who may drop out.
- ❖ The number of alternate students admitted may not exceed 10% of the school's approved number of students per class.
- ❖ Prior to admission, alternate students must be informed in writing of their alternate status and that they may be dropped from the program.
- ❖ Alternate students may participate in classes until the commencement of scheduled clinical experience at approved clinical facilities.
- ❖ Upon commencement of clinical experience at approved clinical facilities, the actual number of students in the class may not exceed the number of students approved by the Board for that particular class.

Note: The number of students a school or program will be allowed to admit to its initial class is based on the program director's request and demonstrated available resources per 16 CCR 2585 and determined after all program documentation is submitted.

Document(s) attached:  Yes  No

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**Section 24: Evaluation methodology for student progress:**

Attach ~~Provide~~ a statement that describes the elements used for evaluation of student progress. (May include grading policy). Explain the process or identify the tool used by the instructor and/or preceptor (if applicable) to evaluate student progress in mastering the course and program objectives. The written narrative must identify objectives or criteria for measuring student progress and the methods for evaluation, action, follow-up, and documentation of outcomes. This methodology may include quizzes, testing, mid-term evaluations etc. for early identification of at-risk students.

Document attached:  Yes  No

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**Section 25: Attendance policy:**

Attach ~~Provide~~ a written narrative describing the school or program's attendance policy in compliance with 16 CCR 2585(h), which must include:

- ❖ Attendance criteria; and,
- ❖ Make-up criteria and forms if applicable which specify appropriate methods for make-up of theory and clinical objectives.

Document attached:  Yes  No

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**Section 26: Grievance policy:**

Attach ~~Provide~~ a description of the program's grievance policy and for providing notice of the policy as required by 16 CCR 2585 (j)(3).

Document attached:  Yes  No

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**Section 27: Required Notices:**

Attach ~~Provide~~ a description of the process to advise students about their rights to contact the Board of program concerns, the program's process for credit granting for previous education and experience, and the program's Board-approved clinical facilities as required by 16 CCR 2585.

Document attached:  Yes  No

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**Section 28: Credit Granting:**

Attach ~~Provide~~ a description of the program's policy for giving credit toward the curriculum requirements, a determination of the curriculum area to which credit is applied, and justification for the credit applied, including how the program plans to comply with requirements for transfer credit for related previous education completed within the last five years in compliance with 16 CCR 2585.1.

Document attached:  Yes  No

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**Section 29: Remediation:**

Attach ~~Provide~~ a description of how the program evaluates student performance to determine the need for remediation, including the program's remediation criteria/policy and actions taken if the student does not fulfill the requirements.

Document attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section 30: Program Resources:**

Attach ~~Provide~~ a detailed description of the program resources, including: classroom(s), library and other learning resources (e.g., texts, videos, software, online materials, and other materials used to assist students to meet the expectations for learning), support services (e.g, course and career counseling, student financial aid advisors), physical space, skills laboratory and equipment to achieve the program's objectives. The program may also submit pictures of the campus and resources to support the included description. (16 CCR 2585 (a))

Document attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

**SECTION 31: Eligibility for Expedited Review of Application (for Individual Owners/Sole Proprietorships Only)**

A. Are you serving in, or have you previously served in, the United States military? (BPC section 114.5)

- Yes
- No

B. If you answered “yes” above, are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces? (BPC section 115.4)

- Yes
- No

If you checked “Yes” for this question, please attach ~~provide~~ the following documentation to receive expedited review: evidence of your current military duty (copy of your military orders) or your previous military service (copy of your DD 214 – Certificate of Release or Discharge from ActiveDuty).

C. Do any of the following statements apply to you:

- Yes
  - No
- You were admitted to the United States as a refugee pursuant to section 1157 of Title 8 of the United States Code,
  - You were granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of Title 8 of the United States Code; or,
  - You have a special immigrant visa and were granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of Title VI of Division F of Public Law 111-8 [relating to Iraqi and Afghan translators/interpreters of those who worked for or on behalf of the United States government].

D. If you selected “yes,” you must attach evidence of your status as a refugee, asylee, or special immigrant visa holder as provided below. Failure to do so may result in application processing delays. “Evidence” shall include:

- Form I-94, arrival/departure record, with an admission class code such as “re” (refugee) or “ay” (asylee) or other information designating the person a refugee or asylee.
- Special Immigrant Visa that includes the “si” or “sq”
- Permanent resident card (Form I-551), commonly known as a “green card,” with a category designation indicating that the person was admitted as a refugee or asylee.
- An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurances to the Board that the applicant qualifies for expedited licensure per Business and Professions Code section 135.4.

**I declare under penalty of perjury under the laws of the State of California that I am authorized to sign this application on behalf of the applicant, that I have read this application and the information provided herein along with any accompanying documents, and that the foregoing and all attachments are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Applicant or Authorized representative: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**NOTICE OF COLLECTION OF PERSONAL INFORMATION**

The information provided in this application will be used by the Board of Vocational Nursing and Psychiatric Technicians (Board) to determine whether the applicant institution qualifies for approval. Unless otherwise specified, all information requested on this application is mandatory. Sections 30, 31, 494.5, and 4531.1 of the California Business and Professions Code and Title 16 CCR section 2581 authorize the collection of this information. Failure to provide any of the required information is grounds for rejection of the application as being incomplete. Information provided may be transferred to the Department of Justice, a District Attorney, a City Attorney, the Franchise Tax Board, the California Department of Tax and Fee Administration, or to another government agency as may be necessary to permit the Board, or the transferee agency, to perform its statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. Each individual or applicant has the right to review their file, except as otherwise provided by the California Information Practices Act. Social security numbers (SSN) and individual taxpayer identification numbers (ITIN) are not considered public records. However, other information provided on this form may be disclosed to a member of the public, upon request, under the California Public Records Act. The Executive Officer of the Board is responsible for maintaining the information in this form, and may be contacted at 2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833, telephone number 916-263-7843 regarding questions about this notice or access to records.



## VERIFICATION OF FACULTY QUALIFICATIONS FORM

**INSTRUCTIONS:** Complete this entire form to demonstrate Compliance with Title 16, California Code of Regulations (16 CCR) §§ 2529 and 2584. Submit separate forms for multiple campuses or programs.

This completed form must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) as part of the application process for a new school or program of vocational nursing or for preparation of psychiatric technicians. The information requested on this form is mandatory pursuant to Title 16 California Code of Regulations sections 2526 or 2581, as applicable. The information provided on this form will be used to evaluate eligibility for Board approval of a new program of vocational nursing or for the preparation of psychiatric technicians. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their Records by contacting the Board's Executive Officer at the above address or telephone number.

1. **Program or School Name** \_\_\_\_\_

2. **Type of Program (check one):**  VN Program  PT Program

3. **Faculty Applicant Full Name** (must match name on license) \_\_\_\_\_

4. **Position Title** (check only one box)

Director  Assistant Director  Instructor  Additional Faculty  Teacher Assistant

(Sections 5-9,12,13)

(Sections 5,7-9,12,13)

(Sections 5, 7-8,12,13)

(Section 10)

(Sections 7,11,12)

5. **Teaching Assignment:** (check all that apply):

Full-Time  Part-Time  Teaching Theory  Teaching Clinical

6. **Position Effective/Start Date (Director Only):** \_\_\_\_\_

7. **Professional License Information** (Complete all that apply and attach a copy of license or licensure):

CA RN Lic #: \_\_\_\_\_  CA LVN Lic #: \_\_\_\_\_  CA PT Lic #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_  Exp. Date: \_\_\_\_\_  Exp. Date: \_\_\_\_\_



**8. Faculty Teaching Qualifications:** You must submit applicable documents to demonstrate compliance with CCR §2529(VN Program) or §2584 (PT Program). Check all applicable box(es). Commonly used documents appear in parentheses.

- Teaching Course: (Certificate of Completion from an approved school or School Transcript). If teaching content is unclear from the certificate or transcript, a copy of the course description from the school's catalog is requested.
- Current Active California Professional License.
- Baccalaureate Degree from Accredited School, University, or College: (Copy of school transcript showing date degree conferred, or diploma verifying program completion). For documents from a foreign jurisdiction, please include certification of equivalency by a foreign credential evaluation service that is a member of the such as National Association of Credential Evaluation Services.
- Valid Teaching Credential: (Copy of Credential). Note that a credential does not constitute proof of a teaching course. The teaching course certificate or transcript from an approved school will need to be included.
- Minimum Qualifications for Faculty and Administrators in California Community Colleges.
  - o Bachelor's Degree; and two years of experience; OR
  - o Associate Degree: and six years of experience

**9. Director and Assistant Director Course Requirements:** You must submit a copy of faculty applicant's certificate or transcript from an ~~accredited institution~~ approved school verifying successful completion of the following courses; Administration; Teaching; and Curriculum Development. If the course content cannot be clearly identified, submit a copy of the catalog course description. Required per Title 16 CCR §§ 2529(c)(1) [VN Director Qualifications], 2529(c)(2) [VN Assistant Director Qualifications]; 2584(c)(1) [PT Director Qualifications], 2584(c)(2) [PT Assistant Director qualifications].

**Check each box to ensure you attached the required documents:**

- Administration
- Teaching
- Curriculum Development

**10. Additional Faculty Only:** Curriculum courses to be taught (check all that apply):

- |                                     |                                       |  |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Anatomy    | <input type="checkbox"/> Pharmacology | <input type="checkbox"/> Normal Growth and Development |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Nutrition    | <input type="checkbox"/> Other: _____                  |

**Check all that apply** (per Regulations, one requirement below must be met for additional faculty):

- Baccalaureate Degree from Approved School, University, or College in Discipline related to curriculum content taught.
- Meets California Community College or California State University Teaching Requirements.

**11. Teacher Assistants Only:** Check the box after reading the following statement:

The Board requires, according to 16 CCR sections 2530 and 2585, that each teacher assistant works under the direction of an approved instructor. No more than one teacher assistant may be assigned to each instructor. Each teacher assistant shall assist the instructor in skills lab and clinical teaching only. The instructor to whom the teacher assistant is assigned shall be available to provide direction to the teacher assistant, as needed. The maximum instructor to student ratio of 1:15 does not increase with the addition of a teacher assistant.

**12. Professional Experience as an RN, LVN or PT**

(Include work experience over the last six years. Document teaching experience in #13 only.)

From: (dd/mm/yy)	To:	Employer/City/State	RN/VN/PT Position/Duties
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**13. Teaching Experience**

Include teaching experience over the last six years in an accredited/approved vocational/practical nursing program, psychiatric technician program or registered nursing program ONLY. DO NOT include CNA, DSD or hospital-based educator.

From: (dd/mm/yy)	To:	Employer/City/State	Theory/Clinical Instructor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information contained in and submitted with this application is true and correct.***

Faculty Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Email Address (New Directors Only): \_\_\_\_\_ Phone #: \_\_\_\_\_

Program Director's Signature: \_\_\_\_\_

Program Director's Name: \_\_\_\_\_

Program Director's Email Address \_\_\_\_\_

**SUMMARY OF INSTRUCTIONAL PLAN PROGRAM HOURS  
VOCATIONAL NURSING PROGRAM**

**Name of Program:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Reference: California Code of Regulations (CCR) Title 16 2532 (Curriculum Hours) and Title 16 2533 (Curriculum Content)

Curriculum Content	Prerequisites	Term 1	Term 2	Term 3	Term 4	Term 5	Term 6	Comments	Totals
Anatomy & Physiology									0
Nutrition									0
Psychology									0
Growth & Development									0
Fundamentals of Nursing									0
Nursing Process									0
Communication including with pts w/psych disorders									0
Patient Education									0
*Pharmacology									0
Medical/Surgical Nursing									0
Communicable Disease									0
Gerontological Nursing									0
Rehabilitation Nursing									0
Maternity Nursing									0
Pediatric Nursing									0
Leadership									0
Supervision									0
Ethics & Unethical Cond.									0
Critical Thinking									0
Culturally Congruent Care									0
End-of-Life Care									0
<b>Total Theory Hours</b>	0	0	0	0	0				<b>0</b>
Skills Lab Hours									0
Simulation <u>Hours</u> (if approved)									0
Clinical Experience <u>Hours</u>									0
<b>Total Clinical Hours</b>	0	0	0	0	0				<b>0</b>

**TOTAL PROGRAM HOURS** \_\_\_\_\_ **0**

**Breakout of Clinical Hours by Topic Areas:**

Topic	Hours
Fundamentals	
Medical-Surgical	
Pediatrics	
Maternity	
Leadership/Supervision	
<b>Total Clinical Hours (should match coll H33)</b>	0

\*Pharmacology shall include:  
 • Knowledge of commonly used drugs and their actions  
 • Computation of dosages  
 • Preparation of medications  
 • Principles of Administration

~~If some hours are integrated (not directly counted) please show these hours within parentheses or brackets.~~

**SUMMARY OF PROGRAM HOURS  
PSYCHIATRIC TECHNICIAN PROGRAM**

**Name of Program:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Reference: California Code of Regulations (CCR) Title 16 2586 (Curriculum Hours) and 2587 (Curriculum Content)

Curriculum Content	Prerequisites	Term 1	Term 2	Term 3	Term 4	Term 5	Term 6	Totals
Anatomy & Physiology								0
Nutrition								0
Psychology								0
Normal Growth & Development								0
Nursing Process								0
Communication								0
Nursing Science								0
Fundamentals								0
Med/Surg								0
Comm Dis								0
Gerontological								0
Patient Education								0
*Pharmacology								0
Developmental Disabilities								0
*Mental Disorders								0
Leadership								0
Supervision								0
Ethics								0
Critical Thinking								0
Culturally Congruent Care								0
End of Life Care								0
								0
								0
								0
<b>Total Theory Hours</b>	0	0	0	0	0	0	0	<b>0</b>
Skills Lab Hours								0
Simulation Hours (if approved)								0
Clinical Experience Hours <del>hrs</del>								0
<b>Total Clinical Hours</b>	0	0	0	0	0	0	0	<b>0</b>
<b>TOTAL PROGRAM HOURS</b>								<b>0</b>

**Breakout of Clinical Hours by Topic Areas:**

Topic	Hours
Nursing Science Fundamentals	0
Nursing Science Medical-Surgical	0
Developmental Disabilities	0
Mental Disorders	0
<b>Total Clinical Hours</b>	<b>0</b>

\*Pharmacology shall include:

- Knowledge of commonly used drugs and their actions
- Computation of dosages
- Preparation of medications
- Principles of Administration

\*Mental Disorders shall include addictive behaviors and eating disorders

~~If some hours are integrated (not directly counted) please show these hours within parentheses or brackets.~~





**INTENT FOR CLINICAL FACILITY PLACEMENT**

**Program Name:** \_\_\_\_\_ **Type:**  VN  PT

**Program Campus Location:** \_\_\_\_\_

**Clinical Experience Address:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Facility Administrator/Director Name:** \_\_\_\_\_

**Name/Title of Person Responsible for Student Placement:** \_\_\_\_\_

**Facility Contact Person:** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Projected Term/Semester for Clinical Site:** \_\_\_\_\_

**Projected Content Area(s):** \_\_\_\_\_

**Projected Number of Students per Rotation:** \_\_\_\_\_

**Facility Director's Printed Name:** \_\_\_\_\_

**Facility Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Program Director's Printed Name:** \_\_\_\_\_

**Program Director's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This completed form must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) to begin the approval process for a new school or program. The information requested on this form is mandatory pursuant to Title 16 California Code of Regulations, sections 2526 or 2587, as applicable. The information provided on this form will be used to identify the proposed school or program and to calculate an estimated wait time until active assignment to a nursing education consultant. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.



## CLINICAL FACILITY VERIFICATION FORM - VN

This form must be completed in its entirety by each health care facility that agrees to provide clinical placement for students of the ~~below proposed~~ educational program listed below. Failure to complete the form may result in a delay in the processing of the application ~~for the proposed program~~.

Program Name: \_\_\_\_\_ Director's Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name of Health Care Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Type of Facility (acute care, SNF, long term care, clinic, private practice office, etc.): \_\_\_\_\_

Name of Director of Nursing/Primary Contact: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Term/Semester Requested: \_\_\_\_\_

	Medical Surgical	Leadership Supervision	Maternity	Pediatrics	Psychology- <del>Mental Health</del>	Fundamentals
Type of units where students can be placed in the health care facility (place X in column):						
Average daily census for each area:						
Number of students placed in the unit at any one time:						
Identify shifts and days available for placement of students in the program:						

Instructor to student ratio \_\_\_\_\_

This facility ~~agrees~~ intends to provide ~~offer~~ clinical placement(s) to this new program.

\_\_\_\_\_  
 Signature of Facility Representative Completing this Form

\_\_\_\_\_  
 Date

This completed form must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) as part of the application process for a new school or program of vocational nursing or for preparation of psychiatric technicians. The information requested on this form is mandatory pursuant to Title 16 California Code of Regulations sections 2526, as applicable. The information provided on this form will be used to evaluate eligibility for Board approval of a new program of vocational nursing or for the preparation of psychiatric technicians. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.



## CLINICAL FACILITY VERIFICATION FORM - PT

This form must be completed in its entirety by each health care facility that agrees to provide clinical placement for students of the ~~below proposed~~ educational program listed below. Failure to complete the form may result in a delay in the processing of the application ~~for the proposed program~~.

Program Name: \_\_\_\_\_ Director's Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name of Health Care Facility: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Type of Facility (acute care, SNF, long term care, clinic, develop. disabled, etc.): \_\_\_\_\_

Name of Director of Nursing/Primary Contact: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Term/Semester Requested: \_\_\_\_\_

	Medical Surgical	Leadership Supervision	Develop. Disabled	Mental Disorders	Fundamentals
Type of units where students can be placed in the healthcare facility (place X in column):					
Average daily census for each area:					
Number of students placed in the unit at any one time:					
Identify shifts and days available for placement of students in the program:					

Instructor to student ratio: \_\_\_\_\_

This facility ~~agrees~~ intends to ~~provide~~ offer clinical placement(s) to this ~~new~~ program.

\_\_\_\_\_  
 Signature of Facility Representative Completing this Form

\_\_\_\_\_  
 Date

This completed form must be submitted to the Board of Vocational Nursing and Psychiatric Technicians (Board) as part of the application process for a new school or program of vocational nursing or for preparation of psychiatric technicians. The information requested on this form is mandatory pursuant to Title 16 California Code of Regulations section 2581, as applicable. The information provided on this form will be used to evaluate eligibility for Board approval of a new program for the preparation of psychiatric technicians. The information may be provided to other governmental agencies, or in response to a court order, subpoena, or public records request. You have a right of access to records containing personal information unless the records are exempted from disclosure. Individuals may obtain information regarding the location of their records by contacting the Board's Executive Officer at the above address or telephone number.





**CONTINUING APPROVAL APPLICATION FOR A VOCATIONAL NURSING  
SCHOOL OR PROGRAM  
\$5,000 Fee**

**Section 1: Program Information**

Program Name: \_\_\_\_\_

Physical Address of Program: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ CA: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Website Address: \_\_\_\_\_

Program Type:       Full Time                               Part Time

Community College       Adult School       Regional Occupational  
Program

Private       Hospital-Based      Other: \_\_\_\_\_

Program Director's Name: \_\_\_\_\_

Director Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Affiliate Campus Only:** If this program is affiliated with an approved school or program, provide all of the following information. "Affiliated" means your school or program has a formal collaborative agreement with an approved school or program, as defined in BPC section 2881, that controls its academic policies and curriculum, and where your school or program agrees to utilize the policies and curriculum of the approved school or program.

Affiliate Campus Name: \_\_\_\_\_

Affiliate Campus Address: \_\_\_\_\_

Affiliate Campus Contact Name: \_\_\_\_\_

Affiliate Campus Contact Telephone Number: \_\_\_\_\_

Affiliate Campus Contact Email Address: \_\_\_\_\_

**Section 2: Contact Person for this Application:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Section 3: Applicant/Ownership Information:**

Full Legal Name of Applicant/Owner of Program \_\_\_\_\_

Address of Applicant: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

For corporation or LLC applicants, please list the following information for each of the principal individuals who are the officer(s), managers or officials of the entity who are responsible for the operations or management of the corporation or LLC.

Individual 1:

Name	Title
_____	_____
Address	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security Number/ITIN	E-mail address
_____	_____

Individual 2:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

Individual 3:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____

City, State, ZIP \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Social Security No./ITIN \_\_\_\_\_

E-mail address \_\_\_\_\_

**Notice:** Collection of the SSN, ITIN, and FEIN is authorized by BPC sections 30 and 31. SSNs, ITINs, and FEINs are used exclusively for the purpose of tax enforcement, and compliance with any judgment or order for family support in accordance with Family Code section 17520. If you fail to disclose your SSN, ITIN, or FEIN, your application will not be processed, and you will be reported to the Franchise Tax Board; they may assess a \$100 penalty against you.

#### Section 4: Form of Business Organization:

The applicant will operate the program as a (check only one):

(Note: For corporations and Limited Liability Companies (LLC), provide a current and active California Secretary of State corporate or LLC entity registration number below. For questions regarding registration requirements, contact the California Secretary of State; their information is available at [www.sos.ca.gov](http://www.sos.ca.gov).)

- Individually Owned/Sole Proprietorship. Social Security No. \_\_\_\_\_
- General Partnership FEIN # \_\_\_\_\_
- Limited Partnership FEIN # \_\_\_\_\_
- Corporation. SOS Reg. #. \_\_\_\_\_
- Limited Liability Company. SOS Reg. #. \_\_\_\_\_
- Government Owned Program

(For corporations, submit the Articles of Incorporation, for an LLC, submit the Articles of Organization, and for partnerships, provide a current executed partnership agreement for the applicant business with this application.)

#### Section 5: Disciplinary History:

Within the preceding 7 years from the date of this application, has the applicant ever had a school or program approval and/or any other license suspended, revoked, placed on probation, or had other disciplinary action, including public reproof or reprimand, taken against a license the applicant has held by a state licensing board in or outside of California?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, attach a statement to this application providing all of the following: (1) the name of the state licensing board that imposed the discipline, (2) the type of discipline imposed, (3) the effective dates of discipline; and (4) a description of the violations found by the state licensing board.

#### Section 6: Organization and Management:

~~Provide~~ Attach an organizational chart which reflects the program's current status; identifies all positions within the program and clearly distinguishes lines of accountability and communication.

Document is attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

## Required Documents/Forms (16 CCR 2526, 2529, 2530, 2532, 2533, and 2534)

### Section 7: Geographic Narrative:

~~Provide~~ Attach a description of the geographic area and community to be served by the proposed school or program (e.g, demographics, numbers of health facilities in the area in need of nursing, or potential future growth of the community).

Document is attached:  Yes  No

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### Section 8: Philosophy of Program:

Attach a document that outlines the program's values, ethics, and beliefs ("philosophy"). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning.

Document is attached:  Yes  No

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### Section 9: Conceptual Framework:

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program.

Document is attached:  Yes  No

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### Section 10: Clinical Facility Placement:

Attach a ~~list of the program's clinical facilities. completed~~ Complete a Clinical Facility Verification Form, Form 55M-3A (New 04/2022), for each new health care facility prior to use. This form must be completed for each health care facility that agrees to provide clinical placement for students of the ~~proposed~~ program. 16 CCR section 2534 requires programs to have clinical facilities adequate as to number, type, and variety of patients treated, and to provide clinical experience for all students in the areas specified by 16CCR section 2533.

Document is attached:  Yes  No

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### Section 11: Terminal Objectives:

~~Submit~~ Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable criteria regarding the student's successful completion of progressive components of the program, i.e. courses, terms, semester. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing of the examination as set forth in section 2510, and being able to perform as a competent entry level vocational nurse.

Document is attached:  Yes  No

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**Section 12: Attach course outlines for each course:**

~~Submit~~ Attach documents that reflect the outline and objectives for specific competencies related to essential elements within separate courses or terms.

Course outlines reflect entry-level competencies within the VN scope of practice, theory and correlated clinical experience, and progressive mastery of subject matter.

Document is attached:  Yes  No

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**Section 13: Instructional plan:**

1. ~~Submit~~ Attach the following form, which is to be completed and submitted with this application: *Vocational Nursing or Psychiatric Technician Program Curriculum Content - Instructional Plan* (Form 55M-2W) (New 04/2022). An instructional plan is a document that correlates theory and clinical content and hours on a weekly basis and provides an overview of the teaching schedule; the document shall commit to curriculum in which theory hours precede clinical hours.
2. Is the instructional plan available to all faculty?  
 Yes  No

Document is attached:  Yes  No

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**Section 14: Daily lesson plans:**

Attach copies of daily lesson plans for courses of instruction in the following subjects (for theory and skills): ~~diabetes~~, fundamentals, medical/surgical nursing, pediatrics, leadership and maternity. A daily lesson plan is a document that correlates the theory and practice for each instruction day for the instructor to follow.

Documents attached:  Yes  No

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**Section 15: Evaluation methodology for curriculum:**

~~Submit~~ Attach an explanation of the process that identifies the method(s) by which the curriculum is evaluated regularly. Submit complete unredacted curriculum reviews based on your stated methodology. The reviews should cover the past 18 months as a sample size.

Document is attached:  Yes  No

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**Section 16: Verification of Faculty Qualifications:**

~~Submit~~ Attach a list of the program's faculty. Complete a ~~this completed form for each faculty member as described in 16 CCR 2529: Verification of Faculty Qualifications Form: (Form 55M-10 New 04/2022)~~ for the program for new faculty prior to employment. (16 CCR 2529.)

Documents attached:  Yes  No

---

**Section 17: Evaluation methodology for clinical facilities:**

~~Submit~~ Attach an explanation of the process and identify the tool(s) i.e. surveys, forms, checklists, used by the program to evaluate the clinical facilities. ~~Submit~~ Attach unredacted clinical facility evaluations based on your stated methodology. The reviews should cover the past 18 months as a sample size.

Document is attached:  Yes  No

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**Section 18: Admission criteria:**

~~Submit~~ Attach an explanation of the policy requirements for admission to the school or program. Documentation must include verification for current students enrolled in the program that the program follows its admission policy. For example, student's entrance examination results, health requirements, letters of recommendation, if noted in the program's stated admission policy.

Document is attached:  Yes  No

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**Section 19: Screening and selection criteria:**

~~Submit~~ Attach a document listing and explaining the criteria for selection of program candidates if there are more qualified applicants than available seats within an upcoming cohort.

Document is attached:  Yes  No

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**Section 20: Student Services List:**

~~Submit~~ Attach a list of resources for provision of counseling and tutoring services for students and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address).

Document is attached:  Yes  No

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**Section 21: Number of students:**

1. Submit the program's current pattern of admissions including frequency and number of students per class. If the program consists of more than one track, i.e., full-time and part-time, weekday and weekend, day and evening, indicate enrollment and frequency for each.
2. ~~Submit~~ Attach a document showing current and projected student enrollment numbers in your program for the next four years.
3. Do you admit alternate students to your program: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If Yes, ~~submit~~ attach a copy of the information you provide to alternate students to define the program's policy.

Documents attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section 22: Evaluation methodology for student progress:**

~~Submit~~ Attach a copy of your evaluation methodology for student progress. (May include grading policy.) Explain the process or identify the tool used by the instructor and/or preceptor (if applicable) to evaluate student progress in mastering the course and program objectives. The written narrative must identify objectives or criteria for measuring student progress and the methods for evaluation, action, follow-up, and documentation of outcomes. This methodology may include quizzes, testing, mid-term evaluations etc. for early identification of at-risk students.

Documents attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section 23: Remediation:**

~~Submit~~ Attach the remediation policy, ~~Submit and~~ a copy of completed remediation forms or documentation of remediation for each student: (a) currently in remediation (b) previously in remediation during any time over the past 18 months ~~four years~~; (c) or a document stating that there are no students on remediation for your program.

Documents attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section 24: Attendance policy:**

~~Submit~~ Attach a current copy of the attendance policy and unredacted records/rosters of all student absences for the current terms or semesters. The record/roster must include the student's name and length of absence(s). If the attendance policy does not specify, list the types of make-up assignment used for theory, skills lab and clinical experience.

Document attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section 25: Grievance policy:**

~~Submit~~ Attach a copy of the current

grievance policy. Document attached: \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No

**Section 26: Required Notices:**

~~Submit~~ Attach copies of all materials provided to students advising the students on their right to contact the Board, credit granting, the school/program's grievance process and a list of approved clinical facilities.

Documents attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Section 27: Credit Granting:**

~~Submit~~ Attach a description of the school or program's policy for giving credit toward the curriculum requirements, a determination of the curriculum area to which credit is applied, and justification for the credit applied, as required by 16 CCR 2535. Also submit documentation that verifies student acknowledgement and understanding of the credit granting policy with student signature and date.

Document attached: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Section 28: Transfer Credit:**

~~Submit~~ Attach documentation for each new cohort (since the last approval) verifying eligible students received or were denied transfer credit per 16 CCR 2535 for the following:

- (1) Approved vocational or practical nursing courses.
- (2) Approved registered nursing courses.
- (3) Approved psychiatric technician courses.
- (4) Armed services nursing courses.
- (5) Certified nurse assistant courses.
- (6) Other courses the school determines are equivalent to courses in the program.

The documentation must include the student's name, term/semester, student identification number, the status of the credit (approved/denied), and signature/date from the student and Program Director.

Documents attached: \_\_\_\_\_ Yes \_\_\_\_\_ No



### Section 29: Competency-Based Credit:

If applicable, ~~submit~~ attach a list of names of all currently enrolled students who, upon admission, indicated related previous work experience. For each of these students, describe the testing, written or practical, conducted by the program, the amount of credit granted and the curriculum area to which credit was applied.

Document attached:  Yes  No

---

### Section 30: Program Resources:

~~Submit~~ Attach a detailed description of the program resources, including: classroom(s), library and other learning resources (e.g., texts, videos, software, online materials, and other materials used to assist students to meet the expectations for learning), support services (e.g., course and career counseling, student financial aid advisors), physical space, skills laboratory and equipment to achieve the program's objectives. The program may also submit pictures of the campus and resources to support the included description. 16 CCR 2530 (a)

Document attached:  Yes  No

---

### Section 31: Faculty Meeting Minutes:

~~Submit~~ Attach copies of ~~each~~ faculty attendance sheets and meeting minutes for each meeting over the past 18 months ~~four years~~. Copies of records for no more than 16 meetings need to be submitted.

Documents attached:  Yes  No

---

### Section 32: Education Equivalency:

~~Submit~~ Attach a list of all currently enrolled students ~~and proof~~ showing status of graduation from high school or the equivalency.

Documents attached:  Yes  No

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### Section 33: Program Hours:

Program hours: ~~Submit~~ Attach ~~with this application~~ the following completed form: *Summary of Instructional Plan Program Hours - Vocational Nursing Program* (Form 55M-2E) (New 04/2022) as a summary of all program hours.

Documents attached:  Yes  No

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**Section 34: Preceptorship:**

Does the program offer a preceptorship:  Yes  No

If Yes, provide the date of the Board’s approval of the preceptorship consistent with 16 CCR 2534.1:\_\_\_\_\_.

**Section 35: For Private Post Secondary Schools ONLY:**

~~Submit~~ Attach a copy of the official document indicating current approval to operate your school by the California Bureau for Private Postsecondary Education.

Document attached:  Yes  No

**Section 36: Fee Reduction Request:**

If requesting a reduction in the continuing approval fee of \$5,000 per 16 CCR 2537.2 based upon a reduction in state funding that directly leads to a reduction in enrollment capacity, you must provide the following with this application:

- A copy of the class rosters for the current semester or term, and the previous three consecutive semesters or terms, which demonstrate a cumulative decline in enrollment of more than 10 percent.

Document attached:  Yes  No

**I declare under penalty of perjury under the laws of the State of California that the foregoing and all attachments are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: CA Zip \_\_\_\_\_

**NOTICE OF COLLECTION OF PERSONAL INFORMATION**

The information provided in this application will be used by the Board of Vocational Nursing and Psychiatric Technicians (Board) to determine whether the applicant institution qualifies for continuing approval. Unless otherwise specified, all information requested on this application is mandatory. Sections 30, 31, 494.5, and 2881.2 of the California Business and Professions Code and Title 16 CCR section

2526 authorize the collection of this information. Failure to provide any of the required information is grounds for rejection of the application as being incomplete. Information provided may be transferred to the Department of Justice, a District Attorney, a City Attorney, the Franchise Tax Board, the California Department of Tax and Fee Administration, or to another government agency as may be necessary to permit the Board, or the transferee agency, to perform its statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. Each individual or applicant has the right to review their file, except as otherwise provided by the California Information Practices Act. Social security numbers (SSN) and individual taxpayer identification numbers (ITIN) are not considered public records. However, other information provided on this form may be disclosed to a member of the public, upon request, under the California Public Records Act. The Executive Officer of the Board is responsible for maintaining the information in this form, and may be contacted at 2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833, telephone number 916-263-7843 regarding questions about this notice or access to records.



**CONTINUING APPROVAL APPLICATION FOR A PSYCHIATRIC TECHNICIAN  
SCHOOL OR PROGRAM  
\$5,000 Fee**

**Section 1: Program Information**

Program Name: \_\_\_\_\_

Physical Address of Program: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ CA: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Website Address: \_\_\_\_\_

Program Type:      \_\_\_\_\_ Full Time                      \_\_\_\_\_ Part Time

\_\_\_\_\_ Community College                      \_\_\_\_\_ Adult School                      \_\_\_\_\_ Regional Occupational  
Program

\_\_\_\_\_ Private                      \_\_\_\_\_ Hospital-Based                      \_\_\_\_\_ Other: \_\_\_\_\_

Program Director's Name: \_\_\_\_\_

Director Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Affiliate Campus Only:** If this program is affiliated with an approved school or program, provide all of the following information. "Affiliated" means your school or program has a formal collaborative agreement with an approved school or program, as defined in BPC section 2881, that controls its academic policies and curriculum, and where your school or program agrees to utilize the policies and curriculum of the approved school or program.

Affiliate Campus Name: \_\_\_\_\_

Affiliate Campus Address: \_\_\_\_\_

Affiliate Campus Contact Name: \_\_\_\_\_

Affiliate Campus Contact Telephone Number: \_\_\_\_\_

Affiliate Campus Contact Email Address: \_\_\_\_\_

**Section 2: Contact Person for this Application:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**Section 3: Applicant/Ownership Information:**

Full Legal Name of Applicant/Owner of Program: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

For corporation or LLC applicants, please list the following information for each of the principal individuals who are the officer(s), managers or officials of the entity who are responsible for the operations or management of the corporation or LLC.

Individual 1:

Name	Title
_____	_____
Address	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security Number/ITIN	E-mail address
_____	_____

Individual 2:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____
City, State, ZIP	Alternate Phone
_____	_____
Social Security No./ITIN	E-mail address
_____	_____

Individual 3:

Name	Title
_____	_____
Address Line 1	Phone
_____	_____

City, State, ZIP \_\_\_\_\_

Alternate Phone \_\_\_\_\_

Social Security No./ITIN \_\_\_\_\_

E-mail address \_\_\_\_\_

**Notice:** Collection of the SSN, ITIN, and FEIN is authorized by BPC sections 30 and 31. SSNs, ITINs, and FEINs are used exclusively for the purpose of tax enforcement, and compliance with any judgment or order for family support in accordance with Family Code section 17520. If you fail to disclose your SSN, ITIN, or FEIN, your application will not be processed, and you will be reported to the Franchise Tax Board; they may assess a \$100 penalty against you.

#### Section 4: Form of Business Organization:

The applicant will operate the program as a (check only one):

(Note: For corporations and Limited Liability Companies (LLC), please provide a current and active California Secretary of State corporate or LLC entity registration number below. For questions regarding registration requirements, please contact the California Secretary of State; their information is available at [www.sos.ca.gov](http://www.sos.ca.gov).)

Individually Owned/Sole Proprietorship. Social Security No. \_\_\_\_\_  
 General Partnership FEIN # \_\_\_\_\_  
 Limited Partnership FEIN # \_\_\_\_\_  
 Corporation SOS Reg # \_\_\_\_\_  
 Limited Liability Company SOS Reg # \_\_\_\_\_  
 Government Owned Program

(For corporations, please submit the Articles of Incorporation, for an LLC, please submit the Articles of Organization, and for partnerships, please provide a current executed partnership agreement for the applicant business with this application.)

#### Section 5: Disciplinary History:

Within the preceding 7 years from the date of this application, has the applicant ever had a school or program approval and/or any other license suspended, revoked, placed on probation, or had other disciplinary action, including public reproof or reprimand, taken against a license the applicant has held by a state licensing board in or outside of California?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, attach a statement to this application providing all of the following: (1) the name of the state licensing board that imposed the discipline; (2) the type of discipline imposed; (3) the effective dates of discipline; and (4) a description of the violations found by the state licensing board.

#### Section 6: Organization and Management:

~~Provide~~ Attach an organizational chart which reflects the program's current status; identifies all positions within the program and clearly distinguishes lines of accountability and communication.

Document is attached:  Yes  No

**Required Documents/Forms (16 CCR 2581, 2584, 2585, 2585.1, 2586, 2587, 2588 and 2588.1)**

**Section 7: Geographic Narrative:**

~~Provide~~ Attach a description of the geographic area and community to be served by the proposed school or program (e.g, demographics, numbers of health facilities in the area in need of psychiatric technicians, or potential future growth of the community).

Document attached:  Yes  No

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**Section 8: Philosophy of Program:**

Attach a document that outlines the program’s values, ethics, and beliefs (“philosophy”). Examples of concepts generally found in a program's philosophy include humanity, society, health, wellness, illness, education, teaching and learning.

Document attached:  Yes  No

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**Section 9: Conceptual Framework:**

Attach a document that guides the overall structure of the curriculum and reflects the philosophy of the program.

Document attached:  Yes  No

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**Section 10: Clinical Facility Placement:**

Attach a list of the program’s clinical facilities. ~~completed~~ Complete a *Clinical Facility Verification Form*, Form 56M-3A (New 04/2022), for each new health care facility. This form must be completed for each health care facility that agrees to provide clinical placement for students of the ~~proposed~~ program. 16 CCR section 2588 requires programs to have clinical facilities adequate as to number, type, and variety of patients treated, and to provide clinical experience for all students in the areas specified by 16CCR section 2587.

Document attached:  Yes  No

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### Section 11: Terminal Objectives:

~~Submit~~ Attach a document that lists terminal objectives to indicate expected student outcomes upon successful completion of the program, including measurable criteria regarding the student's successful completion of progressive components of the program, i.e. courses, terms, semester. Concepts generally found within terminal objectives include successful completion of program hours and/or objectives, passing examinations as set forth in section 2570, and being able to perform as a competent entry level psychiatric technician.

Document attached:  Yes  No

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### Section 12: ~~Attach course outlines~~ for each course:

~~Submit~~ Attach documents that reflect the outline and objectives for specific competencies related to essential elements within separate courses or terms.

Course outlines reflect entry-level competencies within the PT scope of practice, theory and correlated clinical experience, and progressive mastery of subject matter

Document attached:  Yes  No

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### Section 13: Instructional Plan:

1. ~~Submit~~ Attach the following form, which is to be completed and submitted with this application: *Vocational Nursing or Psychiatric Technician Program Curriculum Content*  
- *Instructional Plan Form 55M-2W (New 04/2022)*. An instructional plan is a document that correlates theory and clinical content and hours on a weekly basis and provides an overview of the teaching schedule; the document shall commit to curriculum in which theory hours precede clinical hours.
2. Is the instructional plan available to all faculty?

Document attached:  Yes  No

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### Section 14: Daily lesson plans:

Attach copies of daily lesson plans for the first two weeks of each course of instruction in the following subjects (for theory and skills): ~~diabetes~~, fundamentals, medical/surgical nursing, leadership, mental disorders and developmentally disabled. A daily lesson plan is a document that correlates the theory and practice for each instruction day for the instructor to follow.

Document(s) attached:  Yes  No

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**Section 15: Evaluation methodology for curriculum:**

~~Submit~~ Attach an explanation of the process that identifies the method(s) by which the curriculum is evaluated regularly. Submit complete unredacted curriculum reviews based on your stated methodology. The reviews should cover the past 18 months as a sample size.

Document attached:  Yes  No

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**Section 16: Verification of Faculty Qualifications:**

~~Submit~~ Attach a list of the program's faculty. Complete a ~~this completed form for each faculty member as described in 16 CCR 2584 Verification of Faculty Qualifications Form: Form 55M-10 (New 04/2022) for new faculty prior to employment. the program. (16 CCR 2584.)~~

Document attached:  Yes  No

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**Section 17: Evaluation methodology for clinical facilities:**

~~Submit~~ Attach an explanation of the process and identify the tool(s) i.e. surveys, forms, checklists, used by the program to evaluate the clinical facilities. Submit unredacted clinical facility evaluations based on your stated methodology. The reviews should cover the past 18 months as a sample size.

Document attached:  Yes  No

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**Section 18: Admission criteria:**

~~Submit~~ Attach an explanation of the policy requirements for admission to the school or program. Documentation must include verification for current students enrolled in the program that the program follows its admission policy. For example, students' entrance examination results, health requirements, letters of recommendation, if noted in the program's stated admission policy.

Document attached:  Yes  No

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**Section 19: Screening and selection criteria:**

~~Submit~~ Attach a document listing and explaining the criteria for selection of program candidates if there are more qualified applicants than available seats within an upcoming cohort.

Document attached:  Yes  No

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**Section 20: Student services list:**

~~Submit~~ Attach a list of resources for provision of counseling and tutoring services for students and corresponding contact information (e.g., primary contact name, telephone number, mailing and/or email address).

Document attached:  Yes  No

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**Section 21: Number of students:**

1. Submit the program's current pattern of admissions including frequency and number of students per class. If the program consists of more than one track, i.e., full-time and part-time, week day and weekend, day and evening, please indicate enrollment and frequency for each.)
2. ~~Submit~~ Attach a document showing current and projected student enrollment numbers in your program for the next four years.
3. Do you admit alternate students to your program:  Yes  No  
If yes, ~~submit~~ attach a copy of the information you provide to alternate students to define the program's policy.

If Yes, submit a copy of the information you provide to alternate students to define the program's policy.

Documents attached:  Yes  No

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**Section 22: Evaluation methodology for student progress:**

~~Submit~~ Attach a copy of your evaluation methodology for student progress. (May include grading policy.) Explain the process or identify the tool used by the instructor and/or preceptor (if applicable) to evaluate student progress in mastering the course and program objectives. The written narrative must identify objectives or criteria for measuring student progress and the methods for evaluation, action, follow-up, and documentation of outcomes. This methodology may include quizzes, testing, mid-term evaluations etc. for early identification of at-risk students.

Documents attached:  Yes  No

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**Section 23: Remediation:**

~~Submit~~ Attach the remediation policy. ~~Submit and~~ attach a copy of completed remediation forms or documentation of remediation for each student: (a) currently in remediation (b) previously in remediation during any time over the past 18 months ~~four years~~; (c) or a document

stating that there are no students on remediation for your program.

Documents attached:  Yes  No

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**Section 24: Attendance policy:**

~~Submit~~ Attach a current copy of the attendance policy and unredacted records/rosters of all student absences for the current terms or semesters. The record/roster must include the student's name and length of absence(s). If the attendance policy does not specify, list the types of make-up assignment used for theory, skills lab and clinical experience.

Document attached:  Yes  No

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**Section 25: Grievance policy:**

~~Submit~~ Attach a copy of the current grievance policy.

Document attached:  Yes  No

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**Section 26: Required notices:**

~~Submit~~ Attach copies of all materials provided to students advising the students on their right to contact the Board, credit granting, the school/program's grievance process and a list of approved clinical facilities.

Documents attached:  Yes  No

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**Section 27: Credit granting:**

~~Submit~~ Attach a description of the school or program's policy for giving credit toward the curriculum requirements, a determination of the curriculum area to which credit is applied, and justification for the credit applied, as required by 16 CCR 2585.1. Also ~~submit~~ attach documentation that verifies student acknowledgement and understanding of the credit granting policy with student signature and date.

Documents attached:  Yes  No

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**Section 28: Transfer credit:**

~~Submit~~ Attach documentation for each new cohort (since the last approval) verifying eligible students received or were denied transfer credit per 16 CCR 2585.1(a) for the following:

- (1) Approved vocational or practical nursing courses.
- (2) Approved registered nursing courses.

- (3) Approved psychiatric technician courses.
- (4) Armed services nursing courses.
- (5) Certified nurse assistant courses.
- (6) Other courses the school determines are equivalent to courses in the program.

The documentation must include the student's name, term/semester, student identification number, the status of the credit (approved/denied), and signature/date from the student and Program Director.

Document(s) attached:  Yes  No

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**Section 29: Competency-based credit:**

If applicable, ~~submit~~ attach a list of names of all currently enrolled students who, upon admission, indicated related previous work experience. For each of these students, describe the testing, written or practical, conducted by the program, the amount of credit granted and the curriculum area to which credit was applied.

Document attached:  Yes  No

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**Section 30: Program resources:**

~~Submit~~ Attach a detailed description of the program resources, including: classroom(s), library and other learning resources (e.g., texts, videos, software, online materials, and other materials used to assist students to meet the expectations for learning), support services (e.g, course and career counseling, student financial aid advisors), physical space, skills laboratory and equipment to achieve the program's objectives. The program may also submit pictures of the campus and resources to support the included description. 16 CCR 2585 (a)

Document attached:  Yes  No

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**Section 31: Faculty meeting minutes:**

~~Submit~~ Attach copies of ~~each~~ faculty attendance sheets and meeting minutes for each meeting over the past 18 months ~~four years~~. Copies of records for no more than 16 meetings need to be submitted.

Documents attached:  Yes  No

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**Section 32: Education equivalency:**

~~Submit~~ Attach a list of all currently enrolled students and proof of graduation from high school or the equivalency.

Documents attached:  Yes  No

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**Section 33: Program hours:**

Program hours: ~~Submit~~ Attach the following completed form: Summary of Program Hours – Psychiatric Technician Program Form 56M-2E (New 04/2022) as a summary of all program hours.

Documents attached:  Yes  No

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**Section 34: Preceptorship:**

Does the program offer a preceptorship:  Yes  No

If Yes, provide the date of the Board's approval of the preceptorship consistent with 16 CCR 2588.1: \_\_\_\_\_.

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**Section 35: For Private Post Secondary Schools ONLY:**

~~Submit~~ Attach a copy of the official document indicating current approval to operate your school by the California Bureau for Private Postsecondary Education.

Document is attached:  Yes  No

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**Section 36: Fee reduction request:**

If requesting a reduction in the continuing approval fee of \$5,000 per 16 CCR 2590.2 based upon a reduction in state funding that directly leads to a reduction in enrollment capacity, you must provide the following:

- A copy of the class rosters for the current semester or term, and the previous three consecutive semesters or terms, which demonstrate a cumulative decline in enrollment of more than 10 percent.
- 

**I declare under penalty of perjury under the laws of the State of California that the foregoing and all attachments are true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: CA Zip \_\_\_\_\_

**NOTICE OF COLLECTION OF PERSONAL INFORMATION**

The information provided in this application will be used by the Board of Vocational Nursing and Psychiatric Technicians (Board) to determine whether the applicant institution qualifies for continuing approval. Unless otherwise specified, all information requested on this application is mandatory. Sections 30, 31, 494.5, and 4531.1 of the California Business and Professions Code and Title 16 CCR section 2581 authorize the collection of this information. Failure to provide any of the required information is grounds for rejection of the application as being incomplete. Information provided may be transferred to the Department of Justice, a District Attorney, a City Attorney, the Franchise Tax Board, the California Department of Tax and Fee Administration, or to another government agency as may be necessary to permit the Board, or the transferee agency, to perform its statutory or constitutional duties, or otherwise transferred or disclosed as provided in California Civil Code Section 1798.24. Each individual or applicant has the right to review their file, except as otherwise provided by the California Information Practices Act. Social security numbers (SSN) and individual taxpayer identification numbers (ITIN) are not considered public records. However, other information provided on this form may be disclosed to a member of the public, upon request, under the California Public Records Act. The Executive Officer of the Board is responsible for maintaining the information in this form, and may be contacted at 2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833, telephone number 916-263-7843 regarding questions about this notice or access to records.