



DATE: June 25, 2015

TO: Directors, Vocational Nursing Programs
Directors, Psychiatric Technician Programs

FROM: Cheryl C. Anderson, M.S., R.N.
Supervising Nursing Education Consultant

SUBJECT: 2015 Annual Report

The Board of Vocational Nursing and Psychiatric Technicians (Board) hereby requests submission of your program's **2015 ANNUAL REPORT**. The report is requested pursuant to authority cited in California Code of Regulations Section 2527 [VN] and Section 2582 [PT].

Reported information should reflect program data from **July 1, 2014 through June 30, 2015** and include the following attachments relative to your vocational nursing and/or psychiatric technician program(s).

- **Attachment A: Enrollment Data.**
- **Attachment B: Program Faculty.**
- **Attachment C: Program Clinical Facilities.**

As used in the ***2015 Annual Report***, the following definitions are employed:

- **Program Completion.** Denotes students' completion of all academic requirements in the program's Board – approved curriculum and met other program requirements, including, but not limited to, tuition, financial assessments, etc.
- **Graduation.** Ceremony during which degrees or diplomas are conferred.
- **Comprehensive Examination.** A thorough and all – inclusive **instructional tool** designed to assess the students' acquisition of theory and clinical knowledge. The examination may encompass an individual class or program curriculum.
- **Predictor Examination.** An **assessment tool** designed to identify the students' level of knowledge and readiness for and probability of success in passing the NCLEX/PN® or CAPTLE.

Please ensure that your report is completed accurately and returned to the Board by **Friday, September 25, 2015**. Failure to submit the required information may result in your program being scheduled to appear before the Board.

Please contact your assigned Nursing Education Consultant should you have questions.



ANNUAL REPORT

July 1, 2014 – June 30, 2015

Vocational Nursing Program Psychiatric Technician Program

PLEASE PROVIDE ALL REQUESTED INFORMATION.

PROGRAM APPROVAL

DUE DATE: SEPTEMBER 25, 2015

SCHOOL/CAMPUS NAME: _____ Full-Time Part-Time

Check Appropriate Box(es): Community College Adult School R.O.P. Private Hospital – Based Other

Official Mailing Address: _____

Program Director: _____ Assistant Director (If Any): _____

Director's Office Telephone: (____) _____ Fax: (____) _____ Email Address: _____

BVNPT Approval Dates: Initial Approval: _____ Last Approval: _____ Expiration: _____ Full-Time Part-Time

Bureau of Private Postsecondary Education Approval: Yes: Expiration Date: _____ No Exempt

Other Accreditations: Yes (Please specify): _____ Expiration Date(s): _____ No

CLASS DATA

1. **Board - approved # of students/class:** Full-Time: _____ Date: _____ Part-Time: _____ Date: _____

2. **Approved frequency of admissions:** Full-Time: _____ Date: _____ Part-Time: _____ Date: _____

3. Was an increase in class size or frequency requested during this reporting period? Yes No

If yes, please provide the following information:

◆ Date of Request: _____ # Requested: _____ Date of Approval: _____ # Approved: _____

4. Does the program conduct classes year round? Full-Time: Yes No Part-Time: Yes No

5. For the period **July 1, 2014 through June 30, 2015**, please provide the following information **per class**.

◆ # Applications Received:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
◆ # Students Admitted:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
List the <u>months</u> and # of students				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____
◆ # Students Completing Program Requirements:	<u>Class #1</u>	<u>Class #2</u>	<u>Class #3</u>	<u>TOTAL</u>
List the <u>months</u> and # of students				
1) Full-Time	_____	_____	_____	_____
2) Part-Time	_____	_____	_____	_____

◆ Please complete and submit **Attachment A Enrollment Data**.

6. When did you **graduate** your **last class**? _____ When is the **next class admission**? _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

CURRICULUM INFORMATION

Please specify the nursing theory on which your program's **conceptual framework** is based, e.g. Maslow, Orem.

Please specify the format of classes in your curriculum. Block* Integrated* Other (*Please specify*): _____

***For example:**

- **Block Format:** A **Nutrition** course would include **only Nutrition content**.
- **Integrated Format:** A **Cardiovascular Nursing** course would include integrated content **related to clients with Cardiovascular deficits**, including, but not limited to, Anatomy & Physiology, Nutrition, Growth & Development, Critical Thinking, Nursing Process, Patient Education, Nursing Care or Interventions, etc. **Integrated content hours should be designated by parentheses.**

Please provide the number of **Board – approved hours/units** for **every content area** below and the date of Board approval. **Integrated content should be reflected by enclosing the hours in parentheses.** Total program hours should include the sum of all **theory and clinical hours**. Please use an asterisk (*) to indicate prerequisite hours/units.

Date of Approval: _____

Vocational Nursing Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Fundamentals		
F. Nursing Process		
G. Communication		
H. Patient Education		
I. Pharmacology		
J. Medical-Surgical Nursing		
K. Communicable Diseases		
L. Gerontological Nursing		
M. Rehabilitation Nursing		
N. Maternity Nursing		
O. Pediatric Nursing		
P. Leadership		
Q. Supervision		
R. Ethics & Unethical Conduct		
S. Critical Thinking		
T. Culturally Congruent Care		
U. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

Date of Approval: _____

Psychiatric Technician Programs Only:	Hours/Units	
	Theory	Clinical
A. Anatomy & Physiology		
B. Nutrition		
C. Psychology		
D. Normal Growth & Development		
E. Nursing Process		
F. Communication		
G. Nursing Science:		
1. Nursing Fundamentals		
2. Med/Surg Nursing		
3. Communicable Diseases		
4. Gerontological Nursing		
H. Patient Education		
I. Pharmacology		
J. Classifications of Developmental Disabilities		
K. Classifications of Mental Disorders		
L. Leadership		
M. Supervision		
N. Ethics & Unethical Conduct		
O. Critical Thinking		
P. Culturally Congruent Care		
Q. End-of Life Care		
TOTAL HOURS/UNITS		
TOTAL PROGRAM HOURS/UNITS:		

INSTRUCTIONAL METHODS

1. Does your program utilize **Distance Education/Learning** as an instructional method? Yes No
2. Does your curriculum include courses that are taught **online or via distance learning**? Yes No

If yes:

 - a. In which term/level are online or distance learning courses presented?

Term I Term II Term III Term IV Other (*Please specify*): _____
 - b. Which classes are presented **online**?

1) Anatomy & Physiology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
2) Nutrition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
3) Psychology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
4) Normal Growth & Development	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
5) Other: (<i>Please Specify</i>) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
3. Does your curriculum include **self – guided learning modules**? Yes No
4. Do your courses include **clinical simulation**? Yes No

If yes:

 - a. Is utilization specific to unit content (*for example: Patient Safety*)? Yes No
 - b. Which courses include **clinical simulation**?

1) Fundamentals of Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
2) Medical/Surgical Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
3) Obstetrical Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
4) Pediatric Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
(Psychiatric Technician Programs Only)				
5) Mental Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
6) Developmental Disabilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> # Theory Hrs: _____	<input type="checkbox"/> # Clinical Hrs: _____
 - c. Do instructors hold current certification in clinical simulation? Yes No
 - d. Is specialized equipment used? Yes No

Please Specify: _____
5. How frequently do you evaluate your **curriculum**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*): _____
6. How frequently do you evaluate your **instructional methodologies**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*): _____
7. How frequently do you evaluate your **clinical facilities and rotations**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*): _____
8. How frequently do you evaluate the **correlation of clinical rotations to presented theory content**?

Quarterly Annually Change in Test Plan Change in Texts Other (*Please Specify*): _____
9. How frequently do you evaluate the **effectiveness of faculty** in teaching assigned curricular content?

Monthly Quarterly Annually Biannually Other (*Please Specify*): _____

TIME BASE

Please indicate **type** (FT=Full-Time, PT=Part-Time, D=Day, E=Evening, or WE=Weekend) and **length** of all classes offered.

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

Type: _____ How is the program divided? Quarters Semesters Modules Other (*Please specify*): _____

Weeks per Quarter/Semester/Module: _____ Total Length of Program: _____ Weeks/Quarters/Semesters

Is a **Preceptorship** included? Yes No Number of Hours: _____ Date of Board Approval: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE INFORMATION ON A SEPARATE PAGE.

ADMISSION, SCREENING & SELECTION PROCESS

1. Please check all **admission criteria** applicable to your program.

12th Grade Completion or Equivalent. Is documented proof required prior to admission? Yes No

Completion of specific admissions test? Yes (*Please specify*): _____ No

Certification (*check all applicable*): HHA CNA CPR Other (*Please specify*): _____

Course prerequisites in addition to those listed on Page 2. (*Please specify*): _____

Are applicants required to demonstrate proficiency in the following? **Select all that apply.**

Language Proficiency Mathematics Medical Terminology Reading Comprehension

Other (*Please specify*): _____

2. Please check all **screening and selection criteria** applicable to your program.

Random Selection Interview Grade Point Average (*Please specify*): _____

Screening Instrument Used:

Assessment Technology Institute (ATI) Career Program Assessment Test (CPAt)

Health Education Systems, Inc. (HESI) Kaplan

National League for Nursing (NLN) Pre Admission Test of Adult Basic Education (TABE)

Wonderlic Other (*Please specify*): _____

Please specify **minimal score required** for admission: _____

Other (*Please specify*): _____

ASSESSMENT TESTS

1. Does the program require students' completion of assessment tests? Yes No
- ◆ If yes, please indicate the **assessment** instrument utilized. (*Check all that apply*)
- Assessment Technology Institute (ATI) **BEFORE** Admission Specialty/Level **AFTER** Course Completion
- Health Education Systems, Inc., (HESI) **BEFORE** Admission Specialty/Level **AFTER** Course Completion
- National League for Nursing (NLN) **BEFORE** Admission Specialty/Level **AFTER** Course Completion
- Other (*Please Specify*): _____ **BEFORE** Admission Specialty/Level **AFTER** Course Completion
- ◆ How many times are students allowed to test? Once Twice Unlimited Other: _____
- PLEASE ATTACH A COPY OF THE INSTRUMENT USED, UNLESS RESTRICTED BY COPYRIGHT.**
2. **Prior to program completion**, are students required to complete: (*Check all that apply*)
- Comprehensive Examination Predictor Examination Other *Please Specify*: _____
- ◆ Is the exam utilized to:
- Evaluate students' **level of achievement** **after** completing your curriculum? Yes No
 - Evaluate students' **readiness** to complete the **licensure examination**? Yes No
- ◆ When is the exam administered? Specialty/Level Completion of Term **AFTER** Course Completion
- ◆ Is a minimum passing score required for program completion? Yes No
- If yes, what is the required passing score? _____
- ◆ Are students **notified** of the requirement **prior** to admission? Yes No
- PLEASE ATTACH A COPY OF STUDENTS' NOTIFICATION.**
3. Do you utilize students' assessment scores to determine curricular modifications? Yes No

EXAMINATION REVIEW COURSES

1. Does the program offer review courses? Yes No
- If yes, check all that apply: NCLEX/PN® CAPTLE Other (*Please specify*): _____
2. What is the **length** of the review course? 3 Days – 1 Wk. 2 Wks. – 3 Wks. Other (*Please specify*): _____
3. Are students required to pass the review course in order to complete the program? Yes No
4. Are students notified of the requirement **prior** to admission? Yes No
5. Is **enrollment restricted** to your program's enrolled students or graduates? Yes No

CAREER MOBILITY

Relative to career mobility, please check **all types** of nursing and related programs offered by your institution.

- CNA to LVN** **LVN to PT** **PT to LVN** **LVN to ADN** Other (*Please specify*): _____

FACULTY MEETINGS

Please indicate the following information regarding your program's faculty meetings.

1. **MEETING FREQUENCY:** Weekly Monthly Quarterly Other (*Please specify*): _____

2. **MEETING CONTENT:** (*Please specify frequency per content area*):

◆ **Attendance:** Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Curriculum Effectiveness:** Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Curriculum Evaluation/Revision:**

▪ Theory-to-Clinical Correlation: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Instructional Methods & Materials: Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Instructor Performance:**

▪ Inter – Course Communication: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Student Concerns: Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Student Achievement:**

▪ Grading: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Readiness for Progression: Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Effectiveness of Remediation:**

▪ Remediation Plans: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Status of Followup Evaluations: Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Criteria for Academic Probation:**

▪ # of Students on Probation: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Areas of Student Deficit: Weekly Monthly Quarterly Other (*Please specify*): _____

▪ Student Progress: Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Program Evaluation:** Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Clinical Facility Evaluation:** Weekly Monthly Quarterly Other (*Please specify*): _____

◆ **Other (*Please specify*):** _____

I HEREBY CERTIFY under penalty of perjury under the laws of the State of California that the information contained in this Annual Report is true and correct.

Program Director's Name: (Print): _____

Program Director's Signature: _____ **Date:** _____

DUE DATE: SEPTEMBER 25, 2015

Attachment A: Enrollment Data

Attachment A should reflect all classes enrolled in your program from July 1, 2014 through June 30, 2015.

Attachment B: Faculty Information

Attachment B should reflect all Board-approved faculty for your program. Please mark through the names of faculty who no longer teach for your program or who vacated the position within the period of this report. The legend for Attachment B is as follows:

- ** Degree:** **A** = Associate Degree; **B** = Bachelors Degree; **M** = Masters Degree;
 D = Doctoral Degree
- *** Position Codes:** **D** = Director; **AD** = Asst. Director; **I** = Instructor or Substitute (nursing);
 AF = Additional Faculty; **TA** = Teacher Assistant
- **** Work Schedule:** **FT** = Full-Time **PT** = Part-Time **S** = Substitute

Attachment C: Clinical Facility Information

Attachment C should reflect all Board-approved clinical facilities in which you have indicated that your program's students received clinical experience during the last **24 months**. Facilities not utilized within that period will be deleted from your program's list of approved clinical facilities. Future use will necessitate the completion of a new Clinical Facility Approval Application. Please mark through any names of facilities you stopped using during this reporting period. The legend for Attachment C is as follows:

- * Non-Use:** Please place a check in this column if the designated facility was not utilized for clinical experience during the last 24 months.
- ** Facility Codes:** **AC** = Acute Care; **AS** = Ambulatory Surgery; **COM** = Community Care;
COR = Corrections; **DC** = Day Care; **GH** = Group Homes;
HH = Home Health; **IC** = Intermediate Care; **SC** = Sub Acute Care;
LTC = Long Term Care; **OP** = Outpatient; **PO** = Physician's Office;
P = Preschool; **PH** = Public Health; **R** = Rehabilitation; **SNF** = Skilled Nursing Facility; **STP** = Specialty Treatment Programs;
SS = Special Schools; **TC** = Transitional Care; **O** = Other (*Please specify*).

PT Programs Only - **CDU** = Chemical Dependency Unit;
MHC = Mental Health Clinics; **P HOSP** = Psychiatric Hospitals;
VE = Vocational Education & Training Centers

- *** Clinical Use Codes:** **Fun** = Fundamentals/Nursing Science; **M/S** = Medical/Surgical;
C Dis = Communicable Diseases; **GERON** = Gerontological Nursing; **REHAB** = Rehabilitation Nursing; **MATERN** = Maternity Nursing; **PED** = Pediatric Nursing; **L/S** = Leadership & Supervision.

PT Programs Only - **MD** = Mental Disorders; **DD** = Developmental Disabilities

Attachment A: Enrollment Data

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Attachment C: Clinical Facility Information

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P = Preschool; **PH** = Public Health; **R** = Rehabilitation; **SNF** = Skilled Nursing Facility; **STP** = Specialty Treatment Programs;
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ATTACHMENT A

ENROLLMENT DATA FORM – INSTRUCTIONS

Please use the following instructions when completing Attachment A – Enrollment Data Form.

- The information to be included in this form is for ALL classes enrolled during the time period specified: July 1, 2014 through June 30, 2015.
- You will need to report **each class separately**. Additional copies of the form may be duplicated as needed.
- One page of the form will accommodate two (2) terms only. If your program is five (5) terms in length, you will need to duplicate the form two (2) more times to account for all five (5) terms.

Note: If the class was only in session for three (3) of the five (5) terms during the reporting period listed above, you will only report those three (3) terms.

- **1** – School and Campus – Enter the school name and campus below the title.
- **2** – Class # - This is your class identifier. This could be a number, a letter, or other notation.
- **3** – Number of Students – Put in the number of students currently in the class.
- **4 and 5** – Full or Part-Time – Indicate if the class is full or part-time (as approved by the Board).
- **6** – Days of Attendance – Select all of the days in which the students will attend.
- **7 through 9** – Indicate if the class is day, evening or a combination of day and evening.
- **10** – Enter the term (or other identifier, level, semester, etc., as appropriate) for this class.
- **11 and 12** – Start and End Date – Enter the dates of the class during this term only and the end date of the term, in this reporting period.
- **13 through 15** Theory, Laboratory and Clinical Hours – Enter the number of theory, laboratory and clinical hours for each content area during the reporting period for this term.

Days: List the days that the students are in theory, laboratory and clinical for this term during the reporting period.

Weeks: List the number of weeks the students were in this term for each content area (theory, laboratory, clinical) during the reporting period.

Teacher(s): List the names of all teacher(s) who taught each content area, theory, laboratory and or clinical, during the reporting period.

Topics/Courses: List the topics taught for this term. Use broad term topics, for example Fundamentals. Do not list the individual lessons taught during Fundamentals.

ENROLLMENT DATA (JULY 1, 2014 THROUGH JUNE 30, 2015)

1. School & Campus													2. Class #	3. # of Students Admitted	4. FT	5. PT																						
Sacramento Vocational Nursing, Sacramento													22	30	X																							
Days of Attendance for this Class													7. Day	8. Evening	9. Day /Evening																							
6. SU		M	X	T	X	W	X	TH	X	F	X	S		X																								
10. Term		1		# Students Currently Enrolled				25		11. Start Date		7/25/14		12. End Date		5/29/15																						
13. Theory Hrs.		160		Days		M/W		Wks.		10		14. Lab Hrs.		100		Days		T/TH		Wks.		8		15. Clinical Hrs.		220		Days		Th/F		Wks.		6				
16. Teacher(s)													Teacher(s)																									
Hinckley													Hinckley, Johnson													Hinckley, Johnson, Gomez												
17. Topic(s)/Courses													Topic(s)/Courses													Topic(s)												
Fundamentals													Basic Care Procedures													Basic Care and Basic Care Procedures												
Nutrition													Medication Administration													Medication Administration towards the end of Term 1												
Pharmacology																										Clinical Site(s)												
Anatomy and Physiology																										Sacramento LTC, Natomas SNF, Elk Grove SNF												
Days of Attendance for this Class													7. Day	8. Evening	9. Day /Evening																							
6. SU		M	X	T	X	W	X	TH	X	F	X	S		X																								
10. Term		2		# of Students Admitted						# of Students Enrolled				11. Start Date		6/1/15		12. End Date		6/30/15																		
13. Theory Hrs.		80		Days		M/W		Wks.		4		14. Lab Hrs.		16		Days		T		Wks.		2		15. Clinical Hrs.		64		Days		T/Th/F		Wks.		4				
16. Teacher(s)													Teacher(s)													Teacher(s)												
Hinckley													Hinckley, Johnson													Hinckley, Johnson, Gomez												
17. Topic(s)/Courses													Topic(s)/Courses													Topic(s)/Courses												
Growth and Development													Sterile procedures													Basic Care & Basic Care Proced., Med.Admin. continued												
Introduction to Medical Surgical Nursing													Wound Care													Treatments, sterile and non-sterile and Wound Care												
																										Clinical Site(s)												
																										Sacramento LTC, Natomas SNF, Elk Grove SNF												
Signature:													Title:													Date:												
Dawn Hinckley, R.N., M.S.N.													Director													7/24/15												

SAMPLE

ENROLLMENT DATA (JULY 1, 2014 THROUGH JUNE 30, 2015)

1. School & Campus													2. Class #	3. # of Students Admitted	4. FT	5. PT	
Days of Attendance for this Class													7. Day	8. Evening	9. Day /Evening		
6. SU		M		T		W		TH		F		S					
10. Term	[] # Students Currently Enrolled					[]					11. Start Date	[] 12. End Date []					
13. Theory Hrs.	[]	Days	[]	Wks.	[]	14. Lab Hrs.	[]	Days	[]	Wks.	[]	15. Clinical Hrs.	[]	Days	[]	Wks.	[]
16. Teacher(s)					Teacher(s)					Teacher(s)							
17. Topic(s)/Courses					Topic(s)/Courses					Topic(s)							
										Clinical Site(s)							
Days of Attendance for this Class													7. Day	8. Evening	9. Day /Evening		
6. SU		M		T		W		TH		F		S					
10. Term	[]	# of Students Admitted	[]	# of Students Enrolled	[]	11. Start Date					12. End Date []						
13. Theory Hrs.	[]	Days	[]	Wks.	[]	14. Lab Hrs.	[]	Days	[]	Wks.	[]	15. Clinical Hrs.	[]	Days	[]	Wks.	[]
16. Teacher(s)					Teacher(s)					Teacher(s)							
17. Topic(s)/Courses					Topic(s)/Courses					Topic(s)/Courses							
										Clinical Site(s)							
Signature: []					Title: []					Date: []							

