



**NURSE AIDE TRAINING
CLINICAL CONTRACT - CHANGE FORM**

Falsified documents submitted to this office will be forwarded to the Attorney General's Office

******* EVERY ITEM MUST BE COMPLETED LEGIBLY AND IN ITS ENTIRETY*******

CHANGES WILL BE EFFECTED **ONLY** UPON RECEIPT OF COMPLETED, LEGIBLE, SIGNED AND DATED FORMS.

School Code _____ (applies to non-facility based programs only)

School/Program Name _____

Address _____

Phone _____

Fax _____

E-mail Address _____

*****List the information requested below for each new or updated Nurse Aide Training clinical contract.*****

Name of Clinical Site _____

Address of Clinical Site _____

Name of NAT Personnel who Signed Contract _____ Title _____

Name of Facility Personnel who Signed Contract _____ Title _____

Contract is Effected on _____ Contract Expires _____

Name of Clinical Site _____

Address of Clinical Site _____

Name of NAT Personnel who Signed Contract _____ Title _____

Name of Facility Personnel who Signed Contract _____ Title _____

Contract is Effected on _____ Contract Expires _____

Name of Clinical Site _____

Address of Clinical Site _____

Name of NAT Personnel who Signed Contract _____ Title _____

Name of Facility Personnel who Signed Contract _____ Title _____

Contract is Effected on _____ Contract Expires _____

Attach a copy of all documentation, referred to above, to this form and maintain in your records for review at survey or when requested. Failure to produce the information when requested will result in a deficiency for your program. Changes will be effected the date received at the registry/DHH. A copy of **all change forms must** be submitted to:

**DHH - Health Standards
P. O. Box 3767
Baton Rouge, La. 70821**

Signature of Authorized Individual _____

Print Name _____ Date _____