

**REQUEST TO ADD OR REPLACE INSTRUCTOR**  
**ADMINISTRATOR CERTIFICATION PROGRAM**

**INSTRUCTIONS:** *At least 30 days before planning to add or replace an instructor for an approved course, vendors must submit this completed form and the required supporting documentation to CDSS, ACS, 744 "P" Street, M.S. 9-14-47, Sacramento, CA 95814.*

(1) **Type of Application:** *(Select applicable box(es).)*  **Add** Instructor  **Replace** Instructor

(2) **Vendor Information:** *(Please print.)* Vendor Number: \_\_\_\_\_

Organization/Vendor Business Name: \_\_\_\_\_

Address *(Street Address, City, State, Zip):* \_\_\_\_\_

Authorized Representative/Contact Person *(Name):* \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**(3) Program Information:**

Type: *(Check one box only.)*  CEU  ICTP

If CEU, Course Title: \_\_\_\_\_ Course Number: \_\_\_\_\_

If ICTP, select the component(s) of the training the instructor is being proposed to teach.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Law & Regs             | <input type="checkbox"/> Community & Support Svcs | <input type="checkbox"/> Cultural Competency            | <input type="checkbox"/> Residents' Rights  |
| <input type="checkbox"/> Business Operations    | <input type="checkbox"/> Physical Needs           | <input type="checkbox"/> Emerg. Intervention/NonViolent | <input type="checkbox"/> Physical Environment                                     |
| <input type="checkbox"/> Management/Supervision | <input type="checkbox"/> Medication               | <input type="checkbox"/> Safety of Foster Youth         | <input type="checkbox"/> Postural Supports, Hospice,<br>& Restricted Health Cond. |
| <input type="checkbox"/> Psych/Social Needs     | <input type="checkbox"/> Admission & Assessment   | <input type="checkbox"/> Alzheimer's & Dementia         |   |

If ICTP, check if  proposed and/or  replaced instructor is/was fulfilling requirements of 22 CCR 84090(i)(1)(A), 85090(i)(1)(A), or 87785(i)(8).

**(4) Instructor Information:** *(Attach the proposed instructor's resume.)*

Name of Instructor to be Replaced: \_\_\_\_\_

Name of Proposed Instructor: \_\_\_\_\_ Social Security Number:\* \_\_\_\_\_

(a) Does the individual currently hold or previously held a license, certification or other approval as a professional in a specified field *(e.g., RN, NHA)*? If yes, please list the type(s) of license(s) or certificate(s) and their number(s). *(Include any Administrator Certificates.)*  YES  NO

(b) Does the individual currently hold or previously held a State-issued care facility license? If yes, please list the type of license(s) and license number(s). *(Include any community care facility licenses.)*  YES  NO

(c) Is the individual currently employed or previously employed by a State-licensed care facility? If yes, please list the facility name(s) and license number(s). *(Place an \* by those where currently employed.)*  YES  NO

(d) Has the individual been the subject of any legal, administrative, or other action involving licensure, certification or other approvals as specified in (a), (b), and (c) above? If yes, please explain and provide the date(s). *(Include any Administrative Actions. Attach additional pages if more space is needed.)*  YES  NO

**(5) Vendor Certification:** I declare that the foregoing information is true and correct to the best of my knowledge.

|   |  |
|---|--|
| Signature of Vendor/Authorized Representative | Printed Name of Vendor/Authorized Representative |
| Title   | Date:  |

**DO NOT WRITE BELOW THIS LINE**

|  |       |
|--|-------|
| Application has been <input type="checkbox"/> approved OR <input type="checkbox"/> disapproved by: | Date: |
|--|-------|

\* Optional but requested for CDSS use only to assist in verifying identity and licensing affiliations. Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.