Print Form

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BASIC NURSE ASSISTANT TRAINING PROGRAM
OFFICIAL CLASS ROSTER

Clinical Group # ________

Program Sponsor ____________ Program # ______ Start Date ________ End Date ________ Must match master schedule

Coordinators Name ____________________ Phone Number ____________________

Coordinators e-mail address ____________________ Date sent to IDPH ________

(Complete and accurate contact information is required). This was a/an: ☐ morning class ☐ afternoon class ☐ evening class ☐ weekend class

Please print or type all student data. Correct and valid U.S. social security numbers must be provided

Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______	Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______
Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______	Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______
Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______	Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______
Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______	Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______
Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______	Social Security Number ______ Last Name ______ First Name ______ Address ______ City, State, Zip ______

Adherence to the 10:1 student to instructor ratio is mandatory for clinical. Submit Master Schedule which matches this Official Class Roster.

Clinical Instructor Name(s) & Code(s): ________ (Type/Print) ________ (Signature)

________ (Type/Print) ________ (Signature)

________ (Type/Print) ________ (Signature)

Approved Evaluator(s) & Code(s): ________ (Type/Print) ________ (Signature)

________ (Type/Print) ________ (Signature)

Lead Theory Instructor Name & Code: ________ (Type/Print) ________ (Signature)

THIS FORM MUST BE MAILED TO THE DEPARTMENT NO LATER THAN 30 DAYS AFTER PROGRAM COMPLETION:

Illinois Department of Public Health
Education and Training
525 West Jefferson Street, 4th Floor
Springfield, Illinois 62761

09/2009