INDIANA DEPARTMENT OF HEALTH TRAINING MASTER SCHEDULE

Schedule is for:	**CNA:** **QMA:**
Class will be:	**In Person:** **Online:** **Hybrid:**
	If this class is online or hybrid, include a lesson plan breakdown of the course, including how classroom hours will be tracked and how often the instructor will have contact with the students.
Program Name:	
Facility/Program Number:	
Address: (City, State, Zip)	
Phone Number:	
Fax Number:	
Email Address:	
Program Director:	
Program Instructor(s):	
Classroom Site and Address:	
Classroom Dates:	Start Date: End Date:
Classroom Times:	Start Time: End Time:
Classroom Days per Week:	Days per week: M____ T____ W____ Th____ F____ Sat____ Sun____
Indicate all dates the class will be conducted outside of the site listed above (i.e. virtual).	
Clinical Site(s) Name(s) and Number(s):	
Clinical Dates:	Start Date: End Date:
Clinical Times:	Start Time: End Time:
Clinical Days per Week:	Days per week: M____ T____ W____ Th____ F____ Sat____ Sun____
Total Proposed Hours:	
Number of Students:	
Dates Class/Clinical Will Not Be in Session:	
Guideline	• Approved programs are requested to copy this form for future use. All approved, non-facility-based programs must submit program schedule information, on this form only**, AT LEAST** 10 days prior to class start date. • **Email this completed form to IDOHLtctrainingprograms@health.in.gov** • **REMINDER:** Any time there are changes (clinical/classroom site or program director/delegated instructor) made to your program, this office MUST be notified, and approval granted, before the change is made. Failure to notify this office can lead to further investigation and possible citation.