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