

**Ohio Department of Health • Division of Quality Assurance
Dining Assistant Program**

246 N. High Street, Columbus, OH 43215 • Telephone (614) 752-8285 • Fax (614) 564-2596

Report of Changes in Dining Assistant Program

(Effective 5/2004)

INSTRUCTIONS: To ensure that this form is processed in a timely manner, please follow the instructions included with each section. You may fax this form to **(614) 564-2596**. **If faxing, please do not send a second copy by mail!** For questions please call 614-752-8285. Please remember:

- ✓ Complete both pages of this form.
- ✓ Include all required documentation as noted in each section.

You will receive a letter acknowledging your changes within 10 business days. If the form is not filled out correctly you will be contacted to provide further information. **Changes should not be implemented until you have received an approval letter from our office.**

Program Information

Program/Nursing Home name			Approval number <div style="text-align: center;">OHDA _____</div>	
Street address			County	
City	ZIP	Program phone ()	FAX ()	
Program Operator		Program Operator phone ()	Cell phone ()	
Date submitted		Proposed date of change		

Please complete the sections that apply.

- To Change the Program OperatorPage 1
- A1** — To Add a InstructorPage 2
- A2** — To Remove a InstructorPage 2
- B1** — To Add a Classroom SitePage 2
- B2** — To Add a Clinical SitePage 2
- B3** — To Remove a Classroom or Clinical SitePage 2

Report of Changes in Dining Assistant Program

Page 2 of 2

Program/Nursing Home name	Approval number
---------------------------	-----------------

SECTION A: Faculty Changes

A1. To Add an Instructor

Instructor name and title	
License number	Expiration date

Is this person replacing a faculty member? ☐ YES ☐ NO (If yes, please complete Section A3)

A2. To Remove an Instructor

✓ If an Instructor is resigning, complete this section.

Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> RD <input type="checkbox"/> OT <input type="checkbox"/> ST	Date of resignation
Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> RD <input type="checkbox"/> OT <input type="checkbox"/> ST	Date of resignation
Name	<input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> RD <input type="checkbox"/> OT <input type="checkbox"/> ST	Date of resignation

SECTION B: Classroom/Clinical Site Changes

B1. To Add a Classroom Site

Name of site			
Address			
City	ZIP	County	Phone
Is classroom site a Long-Term Care Facility? <input type="checkbox"/> YES <input type="checkbox"/> NO		Room capacity	
Is this site replacing another classroom site? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, what site?	

B2. To Add a Clinical Site

Name of site			
Address			
City	ZIP	County	Phone
Is this site replacing another clinical site? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, what site?	

B3. To Remove a Classroom or Clinical Site

Name of site		<input type="checkbox"/> Class site	<input type="checkbox"/> Clinical
Site address			
City	ZIP	County	

Program Operator signature	Date
----------------------------	------