Iowa Training Project for Child Care Nurse Consultants
FY21 Enrollment Agreement

Nurse's Name: _____	Supervisor Name: _____
Nurse's Position Title: _____	Supervisor Email: _____
	Supervisor Telephone: _____
Employer Name: _____	
Office Address: _____	
Office Telephone: _____	

Statements of Assurance

Nurse, Employer and Child Health Director, please read and initial all statements of assurance.

☐ ☐ ☐ The nurse's employer has a written agreement with the following Title V MCAH agency for CCNC services: (*Name of Child Health Agency*)_____

☐ ☐ ☐ The nurse will be employed _____ hours per week for completion of Iowa Training Project for Child Care Nurse Consultant coursework.

☐ ☐ ☐ The nurse has a business work space, telephone, access to the Internet, the *Prepare Iowa Learning Source site,* and an individual business related email address for communication purposes.

☐ ☐ ☐ The nurse's employer supports the *Child Care Nurse Consultant (CCNC) Role Guidance: To Achieve Performance Measures and Annual Performance Standards* and the nurse will adhere to these standards.

☐ ☐ ☐ The nurse will satisfactorily complete all assignments as directed by the course syllabus and/or instructor within 3 months. If training cannot be completed within 3 months, the agency must provide rationale and a timeline for completion, not to exceed 6 months.

☐ ☐ ☐ The nurse agrees to allow instructors and staff associated with the Iowa Training Project for Child Care Nurse Consultants to communicate and consult with the nurse's supervisor/employer, preceptors, practicum site staff, and the MCAH Agency(ies), related to the nurse's performance, progress, and status in the course.

☐ ☐ ☐ The nurse will submit only original, personally authored work, with proper citations for work authored by others. The nurse will not falsify, fabricate, or misrepresent information, citations, data, visits or communication related to assignments in the course. Work that does not adhere to this standard is cause for immediate termination of the course.

Supervisor's Signature (**required**) ___________________________________Date _____

Applicant's Signature (**required**) _____________________________________Date _____

Child Health Agency Director's Signature ____________________________________Date _____

Return the Enrollment Agreement to: email: Heidi.hotvedt@idph.iowa.gov Mail payment ($200) along with this Enrollment Agreement to Iowa Department of Public Health, Attention: Jennifer Deeds Healthy Child Care Iowa, 321 E. 12th Street, Des Moines, IA 50319-0075.