



# Director of Nursing (DON) Training

**May 22-24, 2018 or October 2-4, 2018**

**8:30 a.m. – 4:30 p.m.**

**Members \$350, Non-Members \$1,750**

**Lunch and Materials Included**

The Director of Nursing Training is designed to prepare long term care nurses at all levels of experience for leadership positions within their facility. The program focuses on key areas of effective management and administration, while also emphasizing resident care.

## **Who should attend?**

Any nurse working in long term care who currently holds or wishes to pursue a leadership position

## **Prerequisites:**

- At least 18 years old
- Pay full tuition before class begins
- Attend all scheduled classes

## **Continuing Education Units:**

Continuing Education Units are not offered for the Director of Nursing Training. A Certificate of Completion, however, will be given to all participants at the conclusion of the course.

## **Course Topics Include:**

- Role of the Director of Nursing
- Quality Management & Process Improvement
- Teamwork & Communication
- Abuse/Neglect & Incident/Accident Reporting
- Nurse Practice Act
- Human Resources
- Managing Clinical Care
- Survey Process and Enforcement
- Five Star Quality Measures

## **Primary Instructor:**

Tabby Lancaster, RN

**For more information, please contact the Association at 501-374-4422 or [registration@arhealthcare.com](mailto:registration@arhealthcare.com).**

# Director of Nursing (DON) Training



Please Check One:  
 **May 22-24, 2018**    **October 2-4, 2018**  
**8:30 a.m. - 4:30 p.m., AHCA Training Room, Suite 175**  
**Members \$350, Non-Members \$1,750**  
**Lunch and Materials Included**

**To register, send this completed form to:**  
**Mail: 1401 W. Capitol Ave., Suite 180, Little Rock, AR 72201 • Fax: 501-374-1077 • Email: registration@arhealthcare.com.**  
The information contained herein, together with all attached documents, will be regarded as property of AHCA.

First Name \_\_\_\_\_ M. \_\_\_\_\_ Last Name \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address *(Confirmation and class materials will be sent to this address)* \_\_\_\_\_

Employer \_\_\_\_\_ Current Title \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

License Number *(if applicable)* \_\_\_\_\_ Dates of Employment \_\_\_\_\_

Attendee's Signature \_\_\_\_\_ Date \_\_\_\_\_

PAYMENT TOTAL: \$ \_\_\_\_\_

Check #: \_\_\_\_\_  Visa  Master Card  American Express

Name on Card: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ V-Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Credit Card Receipt to: \_\_\_\_\_

**SPACE IS LIMITED. ADVANCED REGISTRATION IS REQUIRED.**  
**PAYMENT DUE BY FIRST DAY OF CLASS.**  
**CONFIRMATION AND ADDITIONAL INFORMATION WILL BE SENT.**

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registration@arhealthcare.com.**