Gerd W. Clabaugh, MPA Director

Kim Reynolds Governor Adam Gregg Lt. Governor

## Iowa Training Project for Child Care Nurse Consultants FY19 Enrollment Agreement

Nurse	e's Name:	Supervisor Name:
Nurse	e's Position Title:	Supervisor Email:
		Supervisor Telephone:
Emple	oyer Name:	
Office	e Address:	
Office	e Telephone:	
		of Assurance
Nu	rse, Employer and Child Health Director, pl	ease read and initial all statements of assurance.
	The nurse's employer has a written agreement CCNC services: ( <i>Name of Child Health Age</i>	ent with the following Title V MCAH agency for ency)
	The nurse will be employed hours per Child Care Nurse Consultant coursework.	er week for completion of Iowa Training Project for
	The nurse has a business work space, teleph learning management system; and an indivi- communication purposes.	none, access to the Internet, the <i>prepareiowa.com</i> dual business related email address for
	The nurse's employer supports the Child Cannual Performance Standards and the nurse	are Nurse Consultant Performance Measures and se will adhere to these standards.
	• • •	signments as directed by the course syllabus and/or out be completed within 3 months, the agency must tion, not to exceed 6 months.
	Child Care Nurse Consultants to communic	site staff, and the MCAH Agency(ies), related to the
	authored by others. The nurse will not falsif	ally authored work, with proper citations for work y, fabricate, or misrepresent information, citations, data, visits or e course. Work that does not adhere to this standard ourse.

Supervisor's Signature (required)	Date
Applicant's Signature (required)	Date
Child Health Agency Director's Signature	Date
Return the Enrollment Agreement to: email: <a href="Meidi.hotvedt@idph.iowa.ge">Heidi.hotvedt@idph.iowa.ge</a> Agreement to Iowa Department of Public Health, Attention: Jennifer Dee Street, Des Moines, IA 50319-0075.	w Mail payment along with Enrollment ds Healthy Child Care Iowa, 321 E. 12 <sup>th</sup>