

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of School	DBA	Training Number (CDPH use only)	Telephone Number	
Address (Number and Street or P.O. Box Number)	City	County	State	Zip

II.

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes," list names, addresses, and telephone numbers of individuals or corporations.

A. Are there any directors of the corporation, management staff of the school, or instructors who have a direct or indirect ownership or control interest of five (5) percent or more in the school that have had Training Program(s) terminated? Yes No

B. Are there any directors or instructors of the school who have had their nursing licensed placed on suspension, probation, diversion, or revocation? Yes No

C. List all sources of student funding:

III.

A. List names, addresses, and telephone numbers for individuals and organizations having direct or indirect ownership or a controlling interest of five (5) percent or more in the school. List any additional names and addresses under "Remarks" on page 2. If more than one (1) individual is reported and any of these persons are related to each other, this must be reported under "Remarks".

NAME	ADDRESS	TELEPHONE NUMBER

B. Type of school: Sole proprietorship Partnership Corporation
 Other (specify): _____

C. If disclosing school is a corporation, list names, addresses of the directors and Employer Identification Number for corporations under "Remarks".

D. Are any owners of the disclosing school also owners of other CNA/HHA Training Programs/schools? Yes No
 (Example: sole proprietor, partnership, or members of Board of Directors)
 If yes, list names, addresses of individuals, and training number(s):

NAME	ADDRESS	TELEPHONE NUMBER

IV.

- A. Has there been a change in ownership or control within the last two (2) years?
If yes, list date: _____ Yes No
- B. Do you anticipate any change of ownership or control within the next two (2) years?
If yes, list date: _____ Yes No
- C. Have you filed for bankruptcy within the last two (2) years?
If yes, list date: _____ Yes No

V. Has there been a change in management, program director, or instructors within the last two (2) years? Yes No
Attach a list with changes.

Name of RN in charge of the training program	License number
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VI. List name, address, and training number of all affiliated schools:

NAME	ADDRESS	TRAINING NUMBER

VII. List all clinical sites used by the school:

NAME	ADDRESS

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of approval or where the school already participates, a termination of approval with the state department, as appropriate.

Name of authorized representative (type or print)	Title
Signature	Date

Remarks