

# New York State Nursing Home Nurse Aide Registry Recertification Form



**Instructions:**

Please print clearly, neatly and completely.

The facility where the nurse aide works or last worked must complete this form. This includes verifying the nurse aide’s personal information. The facility must provide a **\$40** company check, certified check or money order made payable to the NYS Commissioner of Health, NYNA. This renewal fee is a nonrefundable processing fee.

Complete both sides of this form then mail to Prometric. A fee shall not be charged by the operator to any nurse aide for any costs associated with recertification [10 NYCRR 415.26(d)(6)(ii)].

Nurse Aide Information													
First Name and Middle Initial:													
Last Name*:													
Social Security Number:													
Prometric ID:													
Date of Birth:													
Home Phone Number:													
Email Address:													
NYS Nurse Aide Certification Number:													
Home Address: <i>(This is the address where the new certificate will be mailed.)</i>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 80%;"></td> <td style="border-bottom: 1px solid black; width: 20%; text-align: right;">Apt. #</td> </tr> <tr> <td style="font-size: small;">Street Address or P.O. Box #</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> </tr> <tr> <td style="font-size: small;">City</td> <td style="font-size: small;">State</td> <td style="font-size: small;">County</td> <td style="font-size: small;">Zip Code</td> </tr> </table>		Apt. #	Street Address or P.O. Box #						City	State	County	Zip Code
	Apt. #												
Street Address or P.O. Box #													
City	State	County	Zip Code										

*\*If this name is a change from what is currently listed on the registry certification, please list the name that is on the current certification: \_\_\_\_\_.*

Nurse Aide Employer Information													
Name of Facility/Agency:													
Address of Facility/Agency:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 80%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> </tr> <tr> <td style="font-size: small;">Street Address or P.O. Box #</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> <td style="border-bottom: 1px solid black; width: 25%;"></td> </tr> <tr> <td style="font-size: small;">City</td> <td style="font-size: small;">State</td> <td style="font-size: small;">Zip Code</td> <td></td> </tr> </table>			Street Address or P.O. Box #						City	State	Zip Code	
Street Address or P.O. Box #													
City	State	Zip Code											
Phone Number of Facility:													
Employer Facility Code:													
Provide dates of employment for this nurse aide: <i>(Staffing agencies should provide dates worked at the NYS health care facility.)</i>	<p>First date of work: (MONTH/DAY/YEAR): _____</p> <p>Is the nurse aide currently employed at the facility listed above?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>If No, provide date of termination: (MONTH/DAY/YEAR): _____</p>												

**Turn over to complete second side of form.**

Prometric ID: \_\_\_\_\_

**To be completed by staffing agencies only.**

Please provide the name of the NYS health care facility or NYS health care provider where the nurse aide worked.

\_\_\_\_\_  
Name of NYS health care facility or NYS health care provider

**Signature of Facility Operator or Designee**

The individual named herein has worked for pay as a nurse aide, under the supervision of a registered nurse, at the health care facility listed above, for at least seven hours within the previous 24-month period. I certify to the best of my knowledge that the information put forth on this New York State Nursing Home Nurse Aide Registry Recertification Form is true and correct.

\_\_\_\_\_  
Signature of Facility Operator or Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title (Printed or typed)

**Please Note:**

If the Recertification is denied or pending for incomplete information, notification may be sent directly to the nurse aide who will be directed to contact the employer. You will receive a monthly report indicating the names of the nurse aides for whom you have submitted renewals during the month and the status of their recertifications. Nurse aides whose certifications are pending for additional information or fees will be included on the report. The nurse aide employer may use another New York State Nursing Home Nurse Aide Registry Recertification Form to submit the missing information by completing the nurse aide's name, Prometric ID and/or certificate number on the form, and the missing information. If the error message is related to non-payment, any fees sent in must include the nurse aide's name and Prometric ID and/or certification number.

**Important Reminder:** Remember to include the \$40 recertification fee with this form. Payment may be made by company check, certified check or money order. Make checks payable to: NYS Commissioner of Health, NYNA. Personal checks and cash are not accepted.

**We suggest that you make a photocopy of this form for your records.**

**Questions:** If you have any questions, please call Prometric at 800.321.6443.

**Mail this completed form and your \$40 recertification fee to:**

Prometric  
Attn: NYS Nurse Aide Registry Recertification  
1260 Energy Lane  
St Paul, MN 55108