



New Mexico Employment Verification Form Required for Nurse Aide Recertification

This form is required to document and verify work experience so you may renew your New Mexico Nurse Aide Certification. To renew your certification, you must have worked for pay as a nurse aide performing nurse aide duties under the supervision of a licensed or registered nurse for at least eight hours during the previous 24-month certification period.

1. If your record in the New Mexico Nurse Aide Registry is flagged for resident abuse or neglect, misappropriation of resident property or Medicaid fraud, your certification will not be renewed.
2. Name changes require that the nurse aide include a copy of the legal documents supporting the requested name change.
3. If you qualify for recertification, your new certification period will be for two years from your last reported date of employment.

Current Information:	Current Registration Expires:	Social Security Number:

Instructions for the nurse aide:

1. Complete Section 1 of this form.
2. Take this form to your nurse aide employer to request that they complete Section 2 of this form.
3. If your work experience as a nurse aide occurred in a Medicaid approved nursing facility and the employer completed Section 2, mail completed form to Prometric. No recertification fee is required.
4. If your work experience as a nurse aide occurred in a non-Medicaid approved nursing facility or for a licensed health care facility or business, mail completed form to Prometric with a \$21 money order or cashier's check made payable to Prometric (cash and personal checks are not accepted). This fee is nonrefundable.

If you have worked as a nurse aide but your past employer refuses to complete Section 2:

1. Complete Sections 1 and 3 of this form.
2. Attach a copy of your W-2 or most recent pay stub showing employment by your former nurse aide employer.
3. Mail this form to Prometric with a \$21 money order or cashier's check made payable to Prometric (cash and personal checks are not accepted). This fee is nonrefundable.

Mail Completed Forms to: Prometric, ATTN: NM NA Program, 1260 Energy Lane, St. Paul, MN 55108

Forms should not be submitted more than 30 days before your current certification expiration period. Forms received more than 60 days after the certification expiration will not be processed. It is recommended that you make a copy of this completed form for your records before mailing. For assistance in completing this form, please call Prometric at 866.391.1945 Monday through Friday between 7 a.m. and 4 p.m. (Mountain Time).

Section 1: Nurse Aide Information

Last Name	First Name	Full Middle Name	Maiden Name (if applicable)
Street Address (including Apt. number or P.O. Box, if applicable)			Social Security Number - -
City		State	ZIP Code
Home Phone Number (including area code) ()	Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth - -
Signature of Nurse Aide:			Date

Section 2: Employment Verification

Instructions:

- Employers must complete this section to verify that the nurse aide worked for their nursing facility, health care facility or business for at least eight hours for pay during the last 24 months performing nurse aide duties under the supervision of a licensed or registered nurse. For Medicaid approved nursing facilities, this includes nurse aides who are or were employed by the facility and/or nurse aides who worked at the facility but were employed by another staffing entity.
- If you are a Medicaid approved nursing facility, an authorized facility representative must complete and sign this section.
- If you are a non-Medicaid approved nursing facility, health care facility or business, this section must be completed and signed by both the Administrator/Director and a licensed, practical or registered nurse who supervised the nurse aide.
- Completing Section 2 is not an endorsement of the nurse aide, the quality of the nurse aide's work or eligibility for rehire. You are simply verifying that the nurse aide worked as a nurse aide for pay providing nurse aide duties at your facility/business.

Name of Nursing Facility or Business	Facility/Business Phone Number (including area code) ()	
Facility or Business Mailing Address		
City	State	ZIP Code
Is your facility a Medicaid Approved Nursing Facility? (check one only)		
<input type="checkbox"/> Yes (Provide Medicaid Provider Code below) <input type="checkbox"/> No (Provide License Number below)		
Medicaid Provider Code (please provide complete code)	License Number:	
	Type of facility/business (check one): <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospital <input type="checkbox"/> Hospice <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Long Term Care	
Nurse Aide's Date of Hire: ___/___/___	Did the nurse aide work for your facility/business for a minimum of eight hours providing nurse aide duties for pay working under the supervision of a licensed, practical or registered nurse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nurse Aide's Last Date of Employment: ___/___/___		

I agree that the information provided in Section 2 of this verification form is correct and may be investigated. I understand that if I have given false information on this form, I may be prosecuted by the State of New Mexico.

Name of Authorized Facility Representative (please print)	Signature of Authorized Facility Representative	Date
Name & License # of Supervising Licensed or Registered Nurse	Signature of Supervising Licensed or Registered Nurse	Date

Section 3: Employment Verification Supported by Pay Stub or W-2

Instructions: Nurse aides may only use this section if their employer refused to complete Section 2. If the employer refused, the nurse aide must complete and sign below. The nurse aide must include the \$21 (includes NM State Tax) renewal fee.

Name of Facility or Business	Phone Number (including area code) ()		
Mailing Address			
City	State	ZIP Code	
Type of Facility (check one)	<input type="checkbox"/> Medicaid approved nursing facility <input type="checkbox"/> Assisted Living <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospital <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other (specify): _____		

I worked at this nursing or health care facility or business from ___/___/___ to ___/___/___ as a nurse aide providing nurse aide related duties for pay under the supervision of a licensed or registered nurse. I attest to the accuracy of the information provided in Sections 1 and 3 of this verification form, as well as to my claim that the employer listed was asked to complete this verification and refused. I understand that it may be investigated. I further understand that if I have given false information on this form, I may be prosecuted by the State of New Mexico.

Signature of Nurse Aide: _____ Date: _____