



New York State Nursing Home Nurse Aide Registry Application

Please print clearly and neatly. Fill out form completely.

If you are a retester, you may not use this form and must use your Retest Letter. If you do not have a copy of your retest letter, contact Prometric for a duplicate. Retest candidates will not be scheduled without a Retest Letter.

Section 1. Candidate Information: MUST be completed by all applicants.

Last Name	First Name	Middle Name	Other/Maiden Name (if applicable)
Street Address (including Apt. number or P.O. Box, if applicable)			
City	State	ZIP Code	County (or Code)
Home Phone Number (including area code) ()	Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth - -
Email Address	Which language do you speak and understand best? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Current Nursing Home Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Per Diem <input type="checkbox"/> Not Employed (If you are currently working in a nursing home, have your Employer complete Section 4 of this application)			
Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? If this question is not answered, you will not be scheduled to test or be placed on the NYS Registry.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than acquittal or dismissal? If this question is not answered, you will not be scheduled to test or be placed on the NYS Registry.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently hold a certification as a nurse aide or are you listed on the nurse aide registry in any state other than New York? If yes, list all the states below and indicate if you are in good standing on the Registry in that state. Good standing means that you have no findings or convictions of resident abuse, neglect or misappropriation of resident belongings. Add an additional sheet of paper if more space is required.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Issuing State	Good standing?	Issuing State	Good standing?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/>	Certification Route (Check only one . See further explanation of routes in this handbook beginning on Page 3.)		
	Route 1. New Nurse Aides		
	Route 2. Reciprocity/CNA From Another State		
	Route 3. Graduate Nurses		
	Route 4. NYS RNs and LPNs: Enter NYS RN/LPN License Number: _____		
	Route 5. Out-of State and Foreign-Trained Nurses		
	Route 6. Trained and Lapsed: Enter NYS Nurse Aide Certificate Number: _____		
	Route 7. Lapsed—Other: Enter NYS Nurse Aide Certification Number: _____		
<input checked="" type="checkbox"/>	Exam Site (Check only one . See Page 7 of this handbook for Regional Exam Site Locations and Codes.)		
	My employer or training program has arranged/will arrange for me to take the examination(s) at their location.		
	I am registering to exam at Regional Exam Site: _____ Code #: _____ (You will be scheduled for the next available appointment at the Regional Exam Site indicated above or in another regional site within a 50-mile radius.)		

Section 2. Applicant's Affidavit: MUST be completed by all applicants.

Agreement of Authorization and Confidentiality	
1	I agree that the New York State Division of Residential Care and Service may investigate the information in this application
2	I understand that exam results will be sent to my approved training program and/or employing nursing home (when applicable).
3	I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by New York State. Further, I understand that if I cheat or engage in other prohibited behavior during the exam I may be disqualified from continuing to take the exam or my exam results may be invalidated.
4	I understand that a record of the successful completion of this competency evaluation and information from and contained on this form will be included in my record in the New York State Nursing Home Nurse Aide Registry.
5	I have read and I understand the information in the New York State Nursing Home Nurse Aide Certification Handbook.
Signature of Applicant	
Date	

Section 3. Optional Applicant Information.

Education Level (Check the box next to your highest education level completed. Check only one box.)		
<input type="checkbox"/> 4th grade or less	<input type="checkbox"/> High School diploma or GED	<input type="checkbox"/> Two-year college degree
<input type="checkbox"/> Between 5th and 8th grades	<input type="checkbox"/> Trade or Technical School Certificate	<input type="checkbox"/> More than two years college, no degree
<input type="checkbox"/> Some High School, did not graduate	<input type="checkbox"/> One or two years college, no degree	<input type="checkbox"/> Four-year college degree or more
Ethnic Group (Check only one box.)		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Mexican American	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Asian American/Pacific Islander	<input type="checkbox"/> Other Hispanic or Latin American	
<input type="checkbox"/> Black/African American	<input type="checkbox"/> White	

Section 4. MUST be completed by your employer.

(This section must be completed by your employer if you are employed in NYS by a Health Care Provider with a Nurse Aide Employer Facility Code.)

Employer Facility Code Number: 3 3	Date of Hire: (MONTH/DAY/YEAR)
What Type of Nurse Aide Employer is the Facility? <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospital <input type="checkbox"/> Staff Agency <input type="checkbox"/> Other : _____	
Name of Facility or Agency Where Employed	
Address of Employer	
City	State ZIP Code
Employer's Signature	Date

Section 5. MUST be completed by the training program coordinator.

(This section must be completed for any applicant who has checked Certification Routes 1, 3, 5 or 7.)

Training Program Code Number: 3 3	Date Program Completed: (MONTH/DAY/YEAR)
Name of Nurse Aide Training Program	
Training Program Mailing Address	
City	State ZIP Code
This exam taker has successfully completed a state-approved Nurse Aide Training Program. Training Program Coordinator/Instructor Signature	Date

Section 6. Fees.

(Retesters must use the Retest Letter to reapply.)

<input checked="" type="checkbox"/>	First-Time Tester (or lapsed tester), Routes 1, 3, 5, 6, 7	Fee	Total
	Clinical Skills AND Written exams	\$115	\$
	Clinical Skills AND Written Oral (for ADA only – must have ADA paperwork)	\$115	\$
	Clinical Skills AND Oral exams	\$135	\$
<input checked="" type="checkbox"/>	Reciprocity and NYS RNs/LPNs Routes 2 and 4	Fee	
	Application Processing Fee—no exam required	\$50	\$
		Total Fee	\$

Payment: Fee(s) may be paid by money order, certified check made payable to "NY Commissioner of Health, NYNA". Your name and ID (if available) must be written on the form of payment. **Personal checks and cash are not accepted. Fees are nonrefundable.**

Mail to:
Prometric
 ATTN: NY Nurse Aide Program
 1260 Energy Lane
 St. Paul, MN 55108