

New York State Nursing Home Nurse Aide Registry Application

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



Note: Before you enter your name below, check the government issued identification that you will use for admission to testing. If the name you use below does not match the name on the identification you provide on the day of testing, you will not be allowed to take your exam.

Last Name		First Name		Middle Name	Other/Maiden Name (if applicable)
Street Address (including Apt. number or P.O. Box, if applicable)					Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male
City		State	ZIP Code		County
Home Phone Number (including area code) ()			Email Address		
Social Security Number - -			Date of Birth - -		
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)					
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?	Issuing State	Good standing?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<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 2.)				
	Route 1. New Nurse Aides				
	Route 2. Reciprocity/CNA From Another State				
	Route 3. Graduate Nurses				
	Route 4. RNs and LPNs licensed in the U.S.: Enter RN/LPN License Number: _____				
	Route 5. Foreign-Trained Nurses				
	Route 6. Trained and Lapsed: Enter NYS Nurse Aide Certificate Number: _____				
	Route 7. Lapsed—Other: Enter NYS Nurse Aide Certification Number: _____				
Exam Site Information (Check one of the following options.)					
<input type="checkbox"/>	In-facility Site: My employer or training program is scheduling my exams and I will take the exams at their facility. I will give this application form to the facility coordinator (do not send it to Prometric).				
<input type="checkbox"/>	Regional Test Site: I am applying to take my exams at a Regional Exam Site. I will receive an admission letter with my specific exam date, time and location.				
	First Choice Exam Site:		Second Choice Exam Site:		

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

Agreement of Authorization, Confidentiality, and Release Statement	
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.
6	I understand that I may be asked to play the part of the resident for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the New York State Department of Health, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
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	Expected Program Completion Date: (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.

Exam Title	Exam Fee	Total
Clinical Skills AND Written exams (first-time tester)	\$115	\$
Clinical Skills AND Oral exams (must have ADA paperwork)	\$115	\$
Clinical Skills AND Oral exams	\$135	\$
Clinical Skills Retest (Prometric ID number _____)	\$68	\$
Written Retest (Prometric ID number _____)	\$57	\$
Oral Retest (Prometric ID number _____)	\$67	\$
Additional Services	Fee	
Reciprocity/CNA From Another State and NYS RNs and LPNs Application Processing	\$50	\$
Duplicate Score Report	\$15	\$
Hand Score Report	\$25	\$
	Total	\$

Payment: Fee(s) may be paid by money order or 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.