



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

Delaware Nurse Aide Application for Reciprocity

General Information

PART I: Eligibility

A nurse aide from another state may apply for certification on the Delaware Nurse Aide Registry instead of completing a Delaware State Approved Nurse Aide Training and/or Competency Examination by meeting the following qualifications:

1. Currently listed on another State's Nurse Aide Registry in good standing.
(You must have a GNA in current/active status if from the State of Maryland)
2. Have no pending or substantiated findings of adult/child abuse, neglect, or misappropriation of resident/patient property recorded on another State's Nurse Aide Registry.
3. Have either been employed as a Certified Nurse Aide for the equivalent of **at least 3 months full time (at least 420 hours)**, for pay, under the supervision of a Registered Nurse or Physician **OR** Have completed a CNA Training Program of **at least 150 hours**.

PART II: Instructions

The following is a checklist of required items:

1. **Section A - Page 2 *Application for Reciprocity*** must be completed by the applicant/CNA. **PLEASE PRINT LEGIBLY.** Please sign the bottom of the page verifying that the information provided is accurate.
2. **Section B – Page 3 *Employer/Training Program Attestation Form*** to be completed by a current or previous employer and requires verification of employment. You must have worked in a health care setting as a CNA under the supervision of a Registered Nurse or Physician; **OR** verification from your CNA Training Program Administrator verifying at least **150 training hours**.
3. Provide verification of certification from the State in which you are currently certified. The Division will verify the status of your certification to assure there are no negative findings.
4. A photo copy of a Picture ID that shows your full (legal) name and your date of birth (i.e. Driver's License or State ID)
5. Processing fee of \$30 - Payment should be made in the form of a **check or money order made payable to: STATE OF DELAWARE**. This fee is non-refundable.

MAIL COMPLETE APPLICATION TO
Division of Long Term Care Residents Protection
3 Mill Road, Suite 308 Wilmington, DE 19806

Original Employer/Training Program Attestation Forms must accompany application; we will no longer accept faxed copies. Applications received without page 3 will be returned to the applicant. Approved applicants will be placed on the Delaware Nurse Aide Registry for a period of two years (24-months); you will be notified via email once your application has been approved. If you do not provide an email address on page 2 of your application you may not receive notification of your certification approval. Please allow up to 30-days for the processing of your application. If you do not receive notification after 30-days you may call (302) 421-7419 to check on the status of your application or search <http://www.prometric.com/nurseaide/DE>



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Employer/Training Program Attestation Form

Applicant Name: _____

Phone Number: _____

SECTION B: To be completed by Employer or Training Program Administrator

NOTE: Photocopies of this form are not acceptable; original signature and notary seal are required.

- 1) This form should be mailed and/or hand delivered to your Employer/Training Program Administrator. Once completed, this form should be returned to applicant and submitted with completed application.
- 2) Employers/Training Schools who do not have a notary available may submit verification on company letterhead. Complete statement 1) or 2) below on official letterhead and submit in lieu of notarized document.

EMPLOYER or TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE NUMBER: _____

Complete either section 1) or 2) below:

- 1) **AS THE EMPLOYER, I certify that individual named above is/was employed as a Certified Nurse Aide and worked FULL TIME from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ OR... Part Time/Per Diem for a total of _____ hours under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.**

Authorized Signature

Date

Sworn and subscribed to me on this _____ day of _____, 20____, in _____ County,
In the State of _____ . (Place Notary Seal Here)

- 2) **AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a Nurse Aide Training and Competency Evaluation Program on _____; the Program was _____ hours.**

Authorized Signature

Date

Sworn and subscribed to me on this _____ day of _____, 20____, in _____ County,
In the State of _____ . (Place Notary Seal Here)