DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office 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. Be currently listed on another State's Nurse Aide Registry in good standing. You must have a current/active GNA certification 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 (or 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** (75 hours Classroom, 75 hours Clinical)**.**

PART II: Instructions - The following is a checklist of required items:

☐ 1. **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. Please answer ALL questions; incomplete forms will be returned.

☐ 2. **Page 3** Employer/Training Program Attestation Form: To be completed by a current or previous employer and requires verification of employment. **This form is NOT to be completed by the CNA**. You must have worked in a health care setting as a CNA under the supervision of a Registered Nurse or Physician. **Pay stubs and/or other documentation will NOT be accepted for verification of employment**. Training Program verification from your CNA Training Program Administrator must verify at least 150 training hours (75 hours Classroom, 75 hours Clinical).

☐ 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**. *We do NOT accept cash. This fee is non-refundable.

MAIL COMPLETED APPLICATION TO
DHSS - Division of Health Care Quality
Attn: Erlease Freeman, CNA Compliance Nurse
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. Upon approval, CNA 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 will not receive this 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

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

TO BE COMPLETED BY NURSE AIDE (must be GNA if from the State of Maryland)

Instructions: Type or print (legibly). Your original signature is required; photocopies of this form will not be accepted.

NAME: _____ _____ _____
(Last Name) **(First Name)** **(Middle Name)**

CURRENT CNA CERTIFICATION NUMBER:_____ **STATE:** _____ **LAST FOUR DIGITS OF SSN:** _____

DATE OF BIRTH:_____/_____/_____ **GENDER:** **Male**_____**Female** _____

MAILING ADDRESS: _____

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

HOME PHONE:_____**CELL PHONE:**_____**EMAIL ADDRESS:** _____

Please circle the appropriate answer:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect, or misappropriation of resident/patient property)? Yes No
   If NO, give details on a separate sheet

2) Have you **EVER** had a negative finding entered against you on any State registry? Yes No
   If YES, give details on a separate sheet

3) Have you **EVER** been convicted of a criminal offense including any guilty pleas and/or no contest pleas? Yes No
   If YES, give details on a separate sheet

4) Have you worked in a healthcare setting as a CNA for at least three months full time or at least 420 hours [for pay] under the supervision of a Registered Nurse or Physician? Yes No
   If YES, please have page 3 completed and notarized by your employer, and attach to this application
   In lieu of notary seal an official letter (on company letterhead) from employer may be submitted

5) If you have not worked for three months full time and/or don't have at least 420 hours, have you completed a CNA Training and Competency Evaluation Program of at least 150 hours? Yes No N/A
   If you answered YES to question #4 above please circle N/A. If you answer YES to this question, please have page 3 completed and notarized by your Training Program Administrator, and attach to this application.

6) Please list **ALL** states in which you have **EVER** been certified (whether currently active or inactive):

_____

***I certify that all information provided above is true and complete. I understand that my application will be denied for submitting false and/or incomplete information and my application fee will be forfeited.**

_____ _____
Signature **Date**

Revised July 2018

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

Employer/Training Program Attestation Form

****TO BE COMPLETED BY EMPLOYER OR TRAINING PROGRAM ADMINISTRATOR (Please use BLACK ink)**

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 official company letterhead.

EMPLOYER or TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____ PHONE NUMBER: _____

CITY:_____STATE:_____ZIP: _____

Complete either section below:

1) **AS THE EMPLOYER, I certify that the individual named above is/was employed as a Certified Nurse Aide and worked FULL TIME from (mm/dd/yyyy)_____to (mm/dd/yyyy)_____ (must be at least three (3) months)**
2) **AS THE EMPLOYER, I certify that the individual named above is/was employed as a Certified Nurse Aide and worked PT/Per Diem for a total of _____ hours (must be at least 420 hours)**

…under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____County, In the State of _____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____

---

3) **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 a total of _____hours [_____ hours class/theory, _____ hours clinical].**

Print Name: _____ Signature: _____
Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____County, In the State of _____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____