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 to the Delaware Nurse Aide Registry in lieu of completing a State Approved Nurse Aide Training and/or Competency Evaluation Program 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, W-2s, and Time and Attendance Records 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 **ALL** States in which you are currently (or have ever been) certified. The Division will verify the status of your certification to assure that 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. The Processing fee of $30 is **NON-REFUNDABLE** if your application is not approved. Payment should be made in the form of a check or money order, and should be made payable to: **STATE OF DELAWARE**.

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 (Page 3) must accompany application; photo copies will NOT be accepted. Incomplete applications will be returned thereby delaying the approval process. Upon approval, applicants will be placed on the Delaware Nurse Aide Registry for a period of two years (24-months). Please allow up to 30-days for the processing of your application. **After 30 days**, you may call (302) 421- 7419 to check on the status of your application. You may also search the website at http://www.prometric.com/nurseaide/DE

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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**.

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

CURRENT CNA CERTIFICATION NUMBER:_____ STATE: _____ SOCIAL SECURITY NUMBER: _____

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

_____

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 your 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? (75 hours classroom, 75 hours clinical) Yes No
   ****If you answered YES to question #4 above please skip this question. If you answer YES to this question, you must have page 3 completed and notarized by your Training Program Administrator and attach to this application.**

***I certify that all information provided 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**

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EMPLOYER/TRAINING PROGRAM ATTESTATION FORM **Name: _____ DOB: _____**

This form is to be completed by the Employer or Training Program Coordinator. Applicants please enter (only) your name and date of birth above.

*Reminder: Photocopies of this form WILL NOT be accepted. Original signature and notary seal are required.

1) This form should be mailed and/or hand delivered to your Employer or Training Program Administrator. Once completed, this form should be submitted along with all other required documentation.
2) Employers and Training Schools who do not have a notary available on site may submit verification on company letterhead. Pay stubs, W-2s, and Time and Attendance Records will NOT be accepted as proof of employment. Please DO NOT send Training Program Certificate of Completion

EMPLOYER or TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____ CITY: _____STATE: _____ ZIP: _____

Complete either section 1) or 2) 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)_____OR…
Worked PART TIME or PER DIEM for a total of _____ hours under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.
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: _____

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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 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: _____