PROMETRIC

Florida Certified Nursing Assistant Examination Application

Instructions:

- Please go to **www.prometric.com/NurseAide/FL** to print the current version of this application and all other forms. **DO NOT submit photocopies** as this may impact the ability to process the application. Incomplete, blurred or illegible forms **will not** be processed.
- To apply online please go to: **www.prometric.com/NurseAide/FL.**
- All submitted applications **must** include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Prometric, ATTN: FL Nurse Aide Program, 7941 Corporate Drive, Nottingham, MD 21236.**

The name you provide on this application **must** match **EXACTLY** the name on your government-issued identification you will provide on the day of testing. If the name does not match **EXACTLY**, you **will not** be permitted to take your exam and **will forfeit** any test fees.

If you have previously taken a nurse aide exam with Prometric and your legal name has changed since then, you **must** provide a **copy** of acceptable legal documentation along with this application. Acceptable documents include marriage certificate; divorce decree; birth certificate; and legal name change court documents. Prometric will be unable to process your application until the legal acceptable documents are received.

- **If applying for Testing Accommodations under the Americans with Disabilities Act (ADA):**
  - Please go to to **www.prometric.com/nurseaide** to print the required ADA Accommodations Request Packet. This packet **MUST** be completed and submitted with this application.
  - Complete and submit the ADA Accommodations Request Packet with this application.
  - Fill out the box below.

Note: *Candidates applying to take the Oral (audio) Exam do not need to apply for ADA accommodations, as this offering is available to all candidates.*

I am applying for **Americans with Disabilities Act (ADA) accommodations.** I am requesting testing accommodations and have included the **required ADA Accommodations Request Packet** along with this application. I understand I must request accommodations **30 days in advance of the test date** and not **all** accommodations can be approved.

☐ **Yes** ☐ **No**

Candidate Information

All fields marked with * are required. Print one number/letter in each box where required.

*Have you taken a Certified Nurse Aide exam with Prometric? ☐ Yes ☐ No

*Social Security Number

☐☐☐-☐☐-☐☐☐☐

*First Name

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Initial

☐

*Last Name

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

*Date of Birth (Month/Day/Year) ☐☐/☐☐/☐☐☐☐	Previous name (if applicable):
*Street Address (including Apt. number or P.O. Box, if applicable)	
*City	*State ☐☐ *ZIP Code ☐☐☐☐☐
*County (first four letters only)	*Daytime Phone Number (including area code) ☐☐☐-☐☐☐-☐☐☐☐
*Email Address (application will not be processed without an email address)	
Ethnic Group (optional)(check one box) ☐ American Indian or Alaskan Native ☐ Asian American/Pacific Islander ☐ Black/African American ☐ Mexican American ☐ Other Hispanic or Latin American ☐ White ☐ Other	
Gender (check one) ☐ Female ☐ Male	

Initial Licensure – Individual

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation. All supporting documentation should be sent to the Florida Department of Health. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☐ No	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? (If you responded "no", skip to #2.)
a. ☐ Yes ☐ No	If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?
b. ☐ Yes ☐ No	If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).
c. ☐ Yes ☐ No	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?
d. ☐ Yes ☐ No	If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).
2. ☐ Yes ☐ No	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss.1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?
a. ☐ Yes ☐ No	If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No	Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 3a.)
a. ☐ Yes ☐ No	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?
4. ☐ Yes ☐ No	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If "No", do not answer 4a or 4b.)
a. ☐ Yes ☐ No	Have you been in good standing with a state Medicaid program for the most recent five years?
b. ☐ Yes ☐ No	Did the termination occur at least 20 years before the date of this application?
5. ☐ Yes ☐ No	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

Disciplinary History (Mandatory)

☐ Yes ☐ No	Have you ever been denied or is there now any proceeding to deny your application for any healthcare certification to practice in Florida or any other state, jurisdiction or country?
☐ Yes ☐ No	Have you ever had disciplinary action taken against your certification to practice any healthcare-related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
☐ Yes ☐ No	Have you ever surrendered a certification to practice any healthcare-related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
☐ Yes ☐ No	Do you have any disciplinary actions pending against your certification?

Criminal History (Mandatory)

☐ Yes* ☐ No	Have you EVER been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies even if adjudication was withheld. Driving under the influence (DUI), driving while impaired (DWI) and driving while license is suspended (DWLS) are not minor traffic offense for purposes of this question. *If you answered YES, please be prepared to create a typed or printed letter with arrest dates, city, state, charges and final dispositions and be prepared to send it to the Board Office upon request. (Do not send this information with your application for examination.)
☐ Yes ☐ No	Have you **EVER** had any records sealed pursuant to section 943.059, F.S., or any other states applicable statute
☐ Yes ☐ No	Have you **EVER** been adjudicated delinquent or have had adjudication of delinquency withheld?

Certification Option/Eligibility

Please check a certification route.

✓	**Certification Training Route**
	E1 - Completed a State-approved Nursing Assistant Training Program. (Complete Training Info section below)
	E2 - Enrolled in a State-approved Nursing Assistant Training Program. (Complete Training Info section below)
	E3 - Challenger. You have never trained as a nursing assistant and have no nursing assistant experience.
	E4 - Other Nursing Training.
	E5 - Lapsed Nursing Assistant.

Training Information

This section must be completed if the applicant has selected Training Route E1 or E2.

***Training Completion Date**: ☐☐/☐☐/☐☐☐☐	Training Program Code (if available – see completion certificate)
*Name of Training Program	
*Training Program Mailing Address (Street Address or P.O. Box)	
City State ☐☐ ZIP Code ☐☐☐☐☐	

Test Site Information

*Please check one of the following options.

✓	**Test Site**	
	Testing at your Facility: My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator. **Do not send to Prometric.**	
	Regional Test Site: I am applying to test at a Regional Test Site. My preferred test site code is listed. *A current list of Test Sites with codes can be found online at www.prometric.com/NurseAide/FL.*	*Test site code:

Exam Selection and Processing/Exam Fees

- **Acceptable Forms of Fee(s) Payment:** certified check, money order, MasterCard, Visa or American Express. Make certified checks payable to Prometric. **Personal checks** and **cash** are **not** accepted. Fees are **non-refundable and non-transferrable.**
- The **Payment Form** (last page) **must** be submitted with this application **regardless of payment type**.

✓	**Exam (Check all that apply)**	**Fee**	**Total**
	Clinical Skills and Written (both in English)	$155	$
	Clinical Skills and Written Audio (both in English)	$155	$
	Written (English)	$35	$
	Written Audio (English)	$35	$
	Clinical Skills (English)	$120	$
	Clinical Skills (English) and Written (Spanish)	$155	$
	Clinical Skills (English) and Written Audio (Spanish)	$155	$
	Written (Spanish)	$35	$
	Written Audio (Spanish)	$35	$
		Total Fee	**$**

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Applicant's Affidavit and Candidate Release Statement

Candidate Attestation

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. (Located in the Candidate Bulletin available online).

☐ Yes ☐ No

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand if information given is not true, my registration status as a nursing assistant may be at risk.
- I understand if I pass both parts of the Nursing Assistant Competency Exam, I will be placed on the Florida Nursing Assistant Registry.
- I understand 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 I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the DHS and OLTC, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand all information required on the registration application may be made available for public disclosure (except for the Social Security Number).

***Candidate Signature (in box below)**

Date: _____

If you **DO NOT** receive your emailed ATT letter from Prometric within **10-14 business days** of receipt at Prometric, please contact Prometric.

Questions: For additional information, please visit our website at **www.prometric.com/nurseaide.**

Please make a copy of all completed forms for your personal records.

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Payment Form

*Candidate Name: _____

*Date of Birth: _____

Note: You have the option of submitting your application and payment online using your credit card at **www.prometric.com/en-us/clients/nurseaide**.

Credit Card Type (Check One)

☐ MasterCard ☐ Visa ☐ American Express

Card Number	Expiration Date ☐☐/☐☐
Amount $ __ __ __ . __ __	C/C Security Code ☐☐☐☐
Name of Cardholder (Print)	
Signature of Cardholder	

Certified Check or Money Order Payments

☐ Certified Check ☐ 3rd Party/Facility Check ☐ Money Order

Certified Check/Money Order/3rd Party/Facility Check Number (one number or letter in each box):
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Please mail completed forms to:

Prometric
ATTN: FL Nurse Aide Program
7941 Corporate Drive
Nottingham, MD 21236.