PROMETRIC

APPCNAFL

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 **www.prometric.com/nurseaide** to print the required ADA Accommodations Request Packet. This packet **MUST** be completed and submitted 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.*

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 the CNA Written or Clinical Skills test before, in Florida, since 2002?

☐ No ☐ Yes ☐ If yes, when was the last time you took the test: _____

*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 ☐☐☐☐☐	
* Phone Number (including area code) ☐☐☐-☐☐☐-☐☐☐☐	
*Email Address (application will not be processed without an email address)	
Race (optional) ☐ White ☐ Black ☐ Native American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other	
Gender (check one) ☐Female ☐Male	
Do you have a High School Diploma or equivalent? ☐YES ☐NO	

***Criminal and Medicaid/Medicare Fraud Questions (Mandatory)**

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. **NOTE**: **This notice only applies to questions 1-5 below.**

***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), Chapter 817, 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" to question 1, skip to question 2.)
a. ☐ Yes ☐ No	If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years before the date of this application?
b. ☐ Yes ☐ No	If "Yes" to 1, for the felonies of the third degree, has it been more than 10 years before the date of this application, except for felonies of the third degree under Section 893.13(6)(a), Florida Statutes?
c. ☐ Yes ☐ No	If "Yes" to 1, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of this application?
d. ☐ Yes ☐ No	If "Yes" to 1, have you successfully completed a pretrial diversion or drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed?
e. ☐ Yes ☐ No	If "Yes" to 1, were you arrested or charged for the felony before July 1, 2009?
***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)? (If you responded "No" to question 2, skip to question 3.)

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 ended for the conviction or plea?
b. ☐ Yes ☐ No	If "Yes" to 2, were you arrested or charged for the felony before July 1, 2009?
***3.** ☐ Yes ☐ No	Have you ever been terminated for cause from the Florida Medicaid Program under Section 409.913, Florida Statutes? (If you responded "No" to question 3, skip to question 4.)
a. ☐ Yes ☐ No	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the past 5 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 you responded "No" to question 4, skip to question 5.)
a. ☐ Yes ☐ No	Have you been in good standing with a state Medicaid program for the past 5 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 (LEIE)?
a. ☐ Yes ☐ No	If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan?
b. ☐ Yes ☐ No	If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE?

*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**. **Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for the 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?

*Health History (Mandatory)

If you answer "Yes" to any of the questions in this section, all supporting documentation should be sent to the Florida Department of Health.

1. ☐ Yes ☐ No	During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice?
2. ☐ Yes ☐ No	In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice?
3. ☐ Yes ☐ No	During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice?
4. ☐ Yes ☐ No	During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse?
5. ☐ Yes ☐ No	During the last five years, have you been enrolled in, required to enter, or participated in any substance related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse?

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

A letter from a Licensed Health Care Practitioner, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

A written self-explanation, identifying the medical condition(s) or occurrence(s); and current status.

*Social Security Number

☐☐☐-☐☐-☐☐☐☐

Pursuant to 466(a)(13), 42 U.S.C. §666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L.Section 317). Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

*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 School or Facility	
*Address of School or Facility (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 Oral (both in English)	$155	$
	Written (English)	$35	$
	Written Oral (English)	$35	$
	Clinical Skills (English)	$120	$
	Clinical Skills (English) and Written (Spanish)	$155	$
	Clinical Skills (English) and Written Oral (Spanish)	$155	$
	Written (Spanish)	$35	$
	Written Oral (Spanish)	$35	$
		Total Fee	**$**

An additional rescheduling/no show fee of $25 is required to reschedule an exam appointment with less than five business days' notice, no- shows, late arrivals, or not allowed to test. Reschedule fees may apply to roster changes made by IFT testing locations.

*Applicant's Affidavit and Candidate Release Statement

*Electronic Fingerprints

Please review the Florida Department of Law Enforcement statement and the Federal Bureau of Investigation document located in the 'Forms' section of the Candidate Bulletin.

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

*Candidate Attestation

- I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.
- I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, 775.083, F.S.
- I further state that I have read and understand ch. 464, F.S., and Rule ch. 64B9, Florida Administrative Code (F.A.C.) as they pertain to the practice of nursing (Note: A current copy of ch. 464 and rule ch. 64B9 may be obtained online at http://www.floridasnursing.gov).
- I understand Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.
- I will comply with all requirements for licensure renewal, including in-service training hours.
- 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 FLDOH, 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 Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

***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.