PROMETRIC

New York Certified Nursing Assistant

Examination Application

Instructions:

- Please go to: **www.prometric.com/NurseAide/NY** 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/NY**
- All submitted applications **must** include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Prometric, ATTN: NY 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.
  - 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 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)	* 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

Education Level (Optional) Check **only one** box next to your highest education level completed.

☐ 4th grade or less
☐ Some High School, did not graduate
☐ One or two years of college
☐ Between 5th and 8th grades
☐ High School diploma or GED
☐ Two-year college degree

*Current Nursing Home Employment Status:

Full Time ☐ Part Time ☐ Not Employed

(If you are currently working in a nursing home, have your Employer complete Section 2 of this application)

Do you currently hold a certification as a nurse aide or are you listed on the nurse aide registry in any state other than New York? If yes, list all the states below and indicate if you are in good standing on the Registry in that state. Good standing means that you have no findings or convictions of resident abuse, neglect or misappropriation of resident belongings. Add an additional sheet of paper if more space is required.

☐ Yes ☐ No

Issuing State	Good standing?	Issuing State	Good standing?	Issuing State	Good standing?
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No

Certification Option/Eligibility

Please check a certification route.

✓	***Certification Route**
	Route 1. New Nurse Aides
	Route 2. Reciprocity/CNA From Another State
	Route 3. Graduate Nurses
	Route 4. RNs and LPNs licensed in the U.S. Enter RN/LPN License Number: _____
	Route 5. Foreign-Trained Nurses
	Route 6. Trained and Lapsed Enter NYS Nurse Aide Certificate Number: _____
	Route 7. Lapsed—Other Enter NYS Nurse Aide Certification Number: _____

PROMETRIC

Training Information

This section must be completed by the Training Program Coordinator for any applicant who has checked Certification Routes **1, 3, 5** or **7**.

*Training Program Code Number: 33☐☐☐☐☐	*Expected Program Completion Date: (MONTH/DAY/YEAR) ☐☐/☐☐/☐☐☐☐
*Name of Training Program	
*Training Program Mailing Address (Street Address or P.O. Box)	
City State ☐☐ ZIP Code ☐☐☐☐☐	
I certify that this applicant has successfully completed a state-approved nurse aide training program.	
Training Instructors Name:	Training Instructor Signature:

Employment Information

This section **must** be completed by your employer if you are employed in NYS by a Health Care Provider with a Nurse Aide Employer Facility Code.

*Employer Facility Code Number: 33☐☐☐☐☐	*Date of Hire: (MONTH/DAY/YEAR) ☐☐/☐☐/☐☐☐☐
*What Type of Nurse Aide Employer is the Facility? ☐ Nursing Home ☐ Home Health Agency ☐ Hospital ☐ Staff Agency ☐ Other	
*Name of Facility or Agency Where Employed	
*Facility Address (Street Address or P.O. Box)	
City State County (first four letters only) ZIP Code	
*Employer Phone Number (including area code) ( )	*Name of Supervisor
*Employer's Signature	Date ☐☐/☐☐/☐☐☐☐

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 it to Prometric).	
☐	**Regional Test Site:** I am applying to test at a Regional Test Site. My preferred test site code is listed. I can find a current list of Test Sites with codes online at **www.prometric.com/NurseAide/NY**.	*Test site code:

Exam Selection and Processing/Exam Fees

- **Acceptable Forms of Fee(s) Payment:** certified check, money order Make certified checks payable to New York State Commissioner of Health, NYNA. **Personal checks** and **cash** are **not** accepted. Fees are **non-transferrable.**
- The **Payment Form** (last page) **must** be submitted with this application **regardless of payment type**.

✓	**First-Time Tester**	**Fee**	**Total**
	Clinical Skills Test AND Written Test	$115	$
	Clinical Skills AND Oral Test (MUST submit ADA Packet)	$115	$
	Clinical Skills AND Oral Test (with Reading Comprehension)	$135	
✓	**Re-tester**	**Fee**	
	Clinical Skills Retest (Prometric ID Number: _____)	$68	
	Written Retest ONLY (Prometric ID Number: _____)	$57	$
	Oral Retest ONLY (Prometric ID Number: _____)	$67	$
✓	**Rescheduling/No Show[2]**	**Fee**	
	Clinical Skills Test	$68	$
	Written Test	$57	$
	Oral Test	$67	$
✓	**Additional Services**	**Fee**	
	Reciprocity/CNA From Another State and NYS RNs and LPNs Application Processing	$50	$
		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

- 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 agree the New York State Division of Residential Care and Service may investigate the information in this application
- I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by New York State. Further, I understand that if I cheat or engage in other prohibited behavior during the exam I may be disqualified from continuing to take the exam or my exam results may be invalidated.
- I understand that a record of the successful completion of this competency evaluation and information from and contained on this form will be included in my record in the New York State Nursing Home Nurse Aide Registry.
- I understand that 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 that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the New York State Department of Health, 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 exam results will be sent to my approved training program and/or employing nursing home (when applicable).
- I understand all information required on the registration application may be made available for public disclosure (except for the Social Security Number).
- I have read and I understand the information in the New York State Nursing Home Nurse Aide Certification Handbook.

***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.

PROMETRIC

Payment Form

*Candidate Name: _____

*Date of Birth:_____

Certified Check or Money Order Payments (Check One)

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

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

Fee(s) may be paid by money order or certified check made payable to "**NY Commissioner of Health, NYNA"**. Your name and ID (if available) must be written on the form of payment. Personal checks and cash are not accepted.

Please mail completed forms, all supporting documentation and fees/letters of Intent to Hire to:

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