North Carolina Department of Health and Human Services

Division of Health Service Regulation

Health Care Personnel Education and Credentialing Section

Phone: 919-855-3969

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# **INSTRUCTIONS**

1. Review Part 1 of the application to determine if you meet the eligibility requirements to be listed on the North Carolina Nurse Aide I Registry.
2. If you meet the eligibility requirements, then complete and submit all pages of the application, including any required supportive documentation. Incomplete applications will not be approved. You must submit the most current version of the application available on the DHSR website.
3. You may type your responses in the fields provided. Example:
4. Return all 12 pages of the completed application with both identifications and any supporting documentation by mail or fax (single sided).
* Mailing Address: 2709 Mail Service Center, Raleigh, NC 27699-2709
* Fax Number: 919-733-9764

**IMPORTANT NOTICES:**

* DHSR has **10 business days** from date of receipt to review the application.
* You will be notified of the status of your application via the email address in your application.
* It is recommended that you use a laptop or desktop computer to complete the application. If you complete the application using a smartphone or tablet, you may experience formatting changes to the document.
* If you submit an incomplete application, then you will be required to resubmit a new application with both identifications.

# **PART 1: DETERMINE ELIGIBILITY**

**Consistent with Rule 10A NCAC 13O .0301, you must meet ALL criteria below**.

1. You are listed as active and in good standing on another State registry of Nurse Aides.

**Important Notice:**

* A temporary listing on a State registry of Nurse Sides will not be accepted.
1. You have no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on any State registry of Nurse Aides.
2. Your employment history as a Nurse Aide meets one of the statements below.
	1. You have been employed as a Nurse Aide for monetary compensation (i.e., for payment or for wages) consisting of at least a total of eight (8) hours of time worked performing nursing or nursing-related tasks assigned/delegated and supervised by a Registered Nurse in the past 2 years (previous 24 consecutive months).
	2. You have not been employed as a Nurse Aide for monetary compensation (i.e., for payment or for wages) because you successfully passed a state-approved Nurse Aide I competency examination and was listed on the registry in the State of reciprocity in the past 2 years (previous 24 consecutive months).

**Important Notice:**

* Private duty Nurse Aide employment type does not meet the eligibility requirements for reciprocity.
1. You have a social security card and an unexpired government-issued identification containing a photograph and signature.

**Important Notices:**

* The name listed on your social security card and unexpired government-issued identification containing a photograph and signature must match.
* The name listed on both identifications must match your name listed on the Nurse Aide registry in the State of reciprocity.
* If the names do not match then you must submit documentation verifying any name changes (e.g., birth certificate, marriage license, divorce decree, notice of resumption of former name, etc.).
1. You completed a state-approved Nurse Aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a state-approved Nurse Aide competency evaluation program that meets the requirements of 42 CFR 483.154.

# **PART 2: APPLICANT INFORMATION**

Instructions:

* **Answer all 12 questions. If you don’t, then your application will not be approved.**
* **Include hyphens and suffixes in the legal name (No Nicknames).**
1. Name of Nurse Aide.

First Name:

Middle Name:

Last Name:

1. Prior Name. Place an X beside the statement Not Applicable if it does not apply.

First Name:

Middle Name:

Last Name:

Not Applicable:

1. Mother’s Maiden Last Name:
2. Mailing Address.

Street:

City:

State:

Zip Code:

County:

1. Social Security Number (all 9 numbers):
2. Date of Birth (mm/dd/yyyy):
3. Email Address:

**Important Notice:**

* The email address you provide will be used by DHSR to communicate the status update regarding your application.
1. Home/Cell Telephone Number (include area code):
2. Place an X Beside the Correct Response.

Male:       Female:

1. Place an X Beside the Correct Response.

Did You Serve in the Military? Yes:       No:

1. Place an X Beside the Correct Response.

Did You Work in a Military Occupational Specialty (MOS) Where You Performed Nursing or Nursing Related Tasks? Yes:       No:

1. Place an X Beside the Correct Response.

Are You Currently Married to an Active Member of the Military or a Military Veteran?

Yes:       No:

# **PART 3: STATE-APPROVED NURSE AIDE I TRAINING & COMPETENCY EVALUATION PROGRAM**

**Instructions:**

**Answer both questions below. If you don’t, then your application will not be approved.**

1. Place an X beside the correct response.

Did You Complete a State-Approved Nurse Aide I Training Program that Consisted of At Least 75 Hours of Training?

Yes:       No:

1. Place an X beside the correct response.

Did You Successfully Pass a State-Approved Nurse Aide I Competency Examination?

Yes:       No:

# **PART 4: NURSE AIDE I REGISTRIES**

**Instructions:**

* **Answer the 3 questions below. If you don’t, then your application will not be approved.**
* **For each active listing, you must include documentation verifying that each registry listing is in good standing in the State of reciprocity.**
	+ The documentation should be dated within thirty (30) calendar days before the date your application is received by the North Carolina Division of Health Service Regulation.
* **If your State of reciprocity is ALABAMA:**
	+ You must submit a signed letter from your current or former employer, on official company letterhead, indicating the following:
		- dates of employment
		- job title
		- duties performed were assigned/delegated and supervised by a Registered Nurse
		- your listing is active and in good standing status
1. List all States where you have an ACTIVE or EXPIRED Nurse Aide I registry listing.

If the information in the table does not match the other state registries, then your application will not be approved.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **State** | **Is Your Registry Listing Active or Expired?**(Place an X beside the correct response) | **Original Issue Date** (mm/dd/yyyy) | **Expiration Date** (mm/dd/yyyy) | **Registry Certification or Registration Number**(Include prefixes and numbers if viewable on the registry) |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |
|       | Active:       Expired:       |       |       |       |

1. Place an X beside the correct response.

Are You Listed on More Than 8 State Nurse Aide Registries in an Active or Expired Status?

Yes:       No:

**Important Notice:**

* + If you answered YES, then you must attach a separate sheet of paper providing the registry information for the States not listed in the table above.
1. Place an X beside the correct response.

Do You Have Any Pending or Substantiated Findings of Abuse, Neglect, Exploitation, or Misappropriation of Resident or Patient Property Recorded on Any State Registry of Nurse Aides? Yes:       No:

**Important Notice:**

* + If you answered YES, then list the States where you have a pending or substantiated finding:

States:

# **PART 5: EMPLOYMENT TYPE**

**Instructions:**

**Answer both questions. If you don’t, then your application will not be approved.**

1. I Worked as a Nurse Aide in the Past 2 Years (previous 24 consecutive months).

Yes:       No:

**Important Notices:**

* If you answered YES, then identify the type of employment where you performed nursing or nursing-related tasks below.
* Private duty Nurse Aide employment type does not meet the eligibility requirements for reciprocity.
* Complete **SECTION A** in Part 6 of the application.

Place an X beside the correct response. Select all that apply.

* Adult/Family Care Home:
* Home Health/Home Care:
* Hospice:
* Hospital:
* Mental Health:
* Nursing Home:
* Other Health Care Facility Type (Please Specify):
1. Place an X beside the correct response.

I Did Not Work as a Nurse Aide in the Past 2 Years (Previous 24 Consecutive Months) Because I Successfully Passed a State-Approved Nurse Aide I Competency Examination.

Yes:       Not Applicable:

 **Important Notices:**

* If you answered Yes, then provide a copy of your school transcript or official documentation from the training program indicating when and where you completed state-approved Nurse Aide I training.
* Complete **SECTION B** in Part 6 of the application.

# **PART 6: EMPLOYMENT HISTORY**

**Instructions:**

Complete Section A or Section B based on your response in Part 5 of the application. If you do not, then your application will not be approved.

* If you worked as a Nurse Aide in the past 2 years (previous 24 consecutive months), then complete SECTION A.
* If you did not work as a Nurse Aide in the past 2 years (previous 24 consecutive months), then complete SECTION B.

**SECTION A**

1. Provide employment information where you performed nursing or nursing-related tasks assigned/delegated and supervised by a Registered Nurse in the past 2 years (previous 24 consecutive months).

**Important Notices:**

* Do not include private duty Nurse Aide employment.
* If this section does not apply to you, please proceed to Section B.

 **Facility/Agency/Employer #1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and Telephone Number of Facility/Agency/Employer:**Name:      Telephone\*:       | **Street/PO Pox:**      | **City:**      | **State and Zip Code:**State:      Zip Code:       |
| \*Do Not Include Your Cell Phone NumberDate of Hire as a Nurse Aide at this Employer (mm/yyyy):       Last Date You Reported for Work as a Nurse Aide at this Employer in the Past 2 years (mm/yyyy):       **Important Notice:*** + You must include a date. Do not include Still Employed, Current, or Present.

Place an X beside the correct response.  |
| Is the Employer a Staffing Agency? Yes:       No:        |
| **Important Notice:*** If you answered YES, then list the States where you worked for the staffing agency in the past 2 years (previous 24 consecutive months):
 |
| Place an X beside the correct response. Did You Work as a Nurse Aide for Monetary Compensation (i.e., For Payment or For Wages) in the Past 2 Years (Previous 24 Consecutive Months)? Yes:       No:       Place an X beside the correct response. Did You Work At Least 8 Hours Performing Nursing or Nursing-Related Tasks Delegated/Assigned and Supervised by a Registered Nurse in the Past 2 Years (Previous 24 Consecutive Months)? Yes:       No:        |
|  |

Provide the First Name and Last Name of the Registered Nurse Who Assigned/Delegated and

Supervised the Duties You Performed as a Nurse Aide at this Employer:

First Name:

Last Name:

**Facility/Agency/Employer #2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and Telephone Number of Facility/Agency/Employer:**Name:      Telephone\*:       | **Street/PO Pox:**      | **City:**      | **State and Zip Code:**State:      Zip Code:       |
| \*Do Not Include Your Cell Phone NumberDate of Hire as a Nurse Aide at this Employer (mm/yyyy):       Last Date You Reported for Work as a Nurse Aide at this Employer in the Past 2 years (mm/yyyy):       **Important Notice:*** + You must include a date. Do not include Still Employed, Current, or Present.

Place an X beside the correct response.  |
| Is the Employer a Staffing Agency? Yes:       No:        |
| **Important Notice:*** + If you answered YES, then list the States where you worked for the staffing agency in the past 2 years (24 consecutive months):
 |
| Place an X beside the correct response. Did You Work as a Nurse Aide for Monetary Compensation (i.e., For Payment or For Wages) in the Past 2 Years (Previous 24 Consecutive Months)? Yes:       No:       Place an X beside the correct response. Did You Work At Least 8 Hours Performing Nursing or Nursing-Related Tasks Delegated/Assigned and Supervised by a Registered Nurse in the Past 2 Years (Previous 24 Consecutive Months)? Yes:       No:        |
|  |

Provide the First Name and Last Name of the Registered Nurse Who Assigned/Delegated and

Supervised the Duties You Performed as a Nurse Aide at this Employer:

First Name:

Last Name:

**Important Notice:**

* + You must attach a separate sheet of paper if you had more than two employers where you performed nursing or nursing-related tasks assigned/delegated and supervised by a Registered Nurse in the past 2 years (previous 24 consecutive months). Do not include private duty Nurse Aide employment.

**SECTION B**

1. Complete this section if you did not work as a Nurse Aide in the past 2 years (previous 24 consecutive months). If this section does not apply to you, please proceed to Part 7 of the application.

List the States where you completed state-approved Nurse Aide I training in the past 2 years (previous 24 consecutive months):

I acknowledge that per federal law [42 CFR 483.156](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.156), any State registry must remove entries for individuals who have performed no nursing or nursing-related services for a period of 24 consecutive months.

First Name (print or type):

Middle Name (print or type):

Last Name (print or type):

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date** (mm/dd/yyyy)**:**

**Important Notice:**

* + You must sign and date the document. An electronic or typed signature will not be accepted.
	+ You must provide a copy of your school transcript or official documentation from the training program indicating when and where you completed state-approved Nurse Aide I training.

# **PART 7: IDENTIFICATIONS**

**Instructions:**

**Read the requirements and acceptable forms of identification below.**

Requirements:

* + You must include a copy of your social security card with the submission of your application.
	+ You must include a copy of an unexpired government-issued identification containing a photograph and signature with the submission of your application.
	+ The name listed on your social security card and unexpired government-issued identification containing a photograph and signature must be identical.
	+ The name listed on both identifications must be identical to the name listed on the Nurse Aide Registry in the State(s) of reciprocity.

Acceptable Forms of Government-Issued Identifications Containing a Photograph and Signature:

* Current, non-expired driver’s license (or expired driver’s license and temporary permit)
* U.S. government-issued Military I.D.
* State-issued identification card
* Passport (US or foreign, current, non-expired)
* Current, non-expired federal-issued employment authorization document (EAD) photo identification card
* Alien registration card

**Important Notices:**

* The First, Middle and Last Name listed on your identifications must be identical and match the name listed in the application. If they do not match, then you must submit legal documentation verifying your name (e.g., birth certificate, marriage license, divorce decree, notice of resumption of former name, etc.). You may be required to update the name in your identifications prior to your application being approved.
	+ Please ensure copies of your identifications are readable before submitting your application. If your identifications are not readable, then you will be asked to resubmit them.

# **PART 8: APPLICANT ATTESTATION**

**I certify that all the information provided in this application is true and complete. I understand that if the information I have provided in this application is found to be fraudulent or inaccurate, then my listing will be removed from the North Carolina Nurse Aide I Registry and I will be required to pass a North Carolina state-approved Nurse Aide I training program and the North Carolina state-approved Nurse Aide I competency evaluation. I give my permission to any State registry to disclose all information requested in this application to the North Carolina Division of Health Service Regulation, Health Care Personnel Education and Credentialing Section.**

First Name (print or type):

Middle Name (print or type):

Last Name (print or type):

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date** (mm/dd/yyyy)**:**

**Important Notice:**

* You must sign and date the document. An electronic or typed signature will not be accepted.

**Reminders:**

* Carefully review your application prior to submitting to DHSR.
* If your application is deemed incomplete, then you will be notified via the email address listed in your application. You will be required to resubmit a new application with both identifications.