

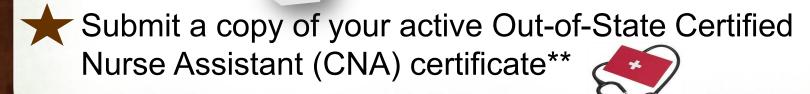
Transferring Your Out-of-State CNA Certificate to California (Reciprocity)

REQUIREMENTS





Complete the Live Scan fingerprint process in California by visiting a Live Scan Agency that provides fingerprinting services and submit the completed Request for Live Scan Service (BCIA 8016) form to our Department



REQUIREMENTS CONTINUED....

**If initial certification was received more than two (2) years ago, please submit proof of work (paystub or W2) to show you have provided nursing or nursing related services in a facility to residents for compensation under the supervision of a licensed health professional within the last two (2) years

Submit a completed Verification of Current Nurse Assistant Certification Form (CDPH 931), which is to be completed by the applicant and submitted to our office by the endorsing state agency

INITIAL APPLICATION (CDPH 283-B)

You must complete an Initial Application (CDPH 283 B), indicating that you are trying to seek Reciprocity in California. California's Initial Application (CDPH 283 B) is used for various processes; therefore, it is important to follow the sample on how to correctly complete the Initial Application (CDPH 283 B) for Reciprocity.

(There is no fee to process your application)

California Department of Public Health (CDPH) Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS) M8 3301, P.O. Box 997416

M8 3301, P.O. Box 997416
Sacramento, CA 98899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785 EMAIL: cna@cdph.ca.gov

CERTIFIED NURSE ASSISTANT (CNA) AND/OR HOME HEALTH AIDE (HHA) INITIAL APPLICATION

		See instructions on the reverse)				
THERE IS NO Last Name	FEE TO PROCESS THIS APPLICATION. YOUR	PAPPLICATION WILL NOT BE PROCESSED IF	ALL APPLICABLE Q	UESTIONS ARE	Sex	RED.
Cook Harric		The Hall		l		_
					Male	Female
Address (Number a	nd Street or P.O. Box Number)	City		State	Zip Code	
Date of Birth	"Social Security Number (SSN)	Driver's License or State ID Nur	nber	Telephone	Number	
		Number:				
		State:				
Helght	Weight	Hair Color		Eye Color		
"If you use an invalid S	SN, your application will not be processed.					
1) Have you be	en CONVICTED, at any time, of any	crime, other than a minor traffic viol	lation? (You nee	d not	Yes	No
	marijuana-related offenses specified afety Code, Sections 11361.5 and 11		and codified at th	ne .		
	arety Code, Sections 11301.5 and 11	Court of conviction:		D:	ite:	
•						
	th-related licensing, certification or di	isciplinary authority taken adverse a	action (revoked, a	annulled,	Yes	No
	spended, etc.) against you? ·s, indicate the type and number of lic	ense/certificate:				
/-	-,					
TYPE OF REQUE	ST (See A or B on the reverse.)					
	f you are enrolling in a CNA training					
Check here	f you are enrolling in a HHA training	program and complete the school p	ortion below.			
Name of School or I	Facility Where you Received / Will Receiv	e the CNA or HHA Training	Telephone Nur	mber		
Mailing Address (No	ımber and Street or P.O. Box Number)	City	•	State	Zip Code	
California Training F	Program ID Number(s) (Required)	•	Beginning Date	of Training	End Date	of Training
Nurse Assistant:	Home Health A	lde				
Check here	if you have EQUIVALENT TRAINING if you are requesting RECIPROCITY	3. (See C on the reverse.)	State:	/00	o D on the	rougero l
Cneck nere	r you are requesting RECIFROCTI T	FROM ANOTHER STATE.	State	(36	e D on the	reverse.)
NAME AND ADD	RESS CHANGES: Certificate holde	ers shall notify CDPH within sixty (6	0) days of any ch	ange of add	iress. If yo	u have had
	submit legal verification of the change		ee, or court docu	ments). Fai	lure to repo	ort a name
or address chang	e may result in the delay or loss of yo	our certification.				
I certify, under pe	nalty of perjury under the laws of the	State of California, that the foregoin	ng is true and co	rrect.		
,						
Signature of Appli	icant		Date			
				Table Hara		
	D BY THE REGISTERED NURSE (RN) F THE TRAINING PROGRAM: I certify tha		FO	R VENDOR	USE ONL	T
completed state and	i federal nurse assistant training requirem	ents and is eligible to take the				
Competency Evalua Training Program in	ation (this section only applies to students	that have recently completed a CNA	1			
mailing Program in	Californiaj.		1			
			1			
Printed Name		Title	1			
			1			
Signature		Date	1			
						Page 1 of 2

INITIAL APPLICATION (CDPH 283 B) SAMPLE

You must complete all areas indicated in yellow

State of California- Health and Human Services Agency

CDPH 283 B (03/13)



California Department of Public Health (CDPH) Licensing and Certification Program (L&C) Alde and Technician Certification Section (ATCS) MS 3301, P.O. Box 997416

PHONE: (916) 327-2445 FAX: (916) 552-8785 EMAIL: cna@cdph.ca.gov

CERTIFIED NURSE ASSISTANT (CNA) AND/OR HOME HEALTH AIDE (HHA) INITIAL APPLICATION

(See instructions on the reverse)

Last Name			First Name			Sex	
						■ Male	Femal
Address (Number	and Street or P.O. Box Number)	City	City			Zip Code	
Date of Birth	"Social Security Number (SSN)		s License or State ID Nun	iber	Telephone I	Number	
		Numbe	er	_			
Height	Weight	State:	oior	_	Eve Color		
			 -	ľ			
If you use an invalid	SSN, your application will not be processed.						
disclose any	een CONVICTED, at any time, of an y marijuana-related offenses specifie Safety Code, Sections 11361.5 and	d in the mariju				Yes	No
	ves, list conviction:		Court of conviction:		Da	ite:	
•	alth-related licensing, certification or			ction (rounked as	Male Female State Zip Code Telephone Number Eye Color d not Yes No ne Date: annulled, Yes No ne State Zip Code e of Training End Date of Training (See D on the reverse.) tange of address. If you have had ments). Failure to report a name		
cancelled, s	ann-related licensing, certification or suspended, etc.) against you? yes, indicate the type and number of		•	•			
TYPE OF DEAL	ICET (Co. A or D or the or or)						
_	JEST (See A or B on the reverse.)			odine balan			
	e if you are enrolling in a CNA trainin e if you are enrolling in a HHA trainin						
	r Facility Where you Received / Will Rece	•. •		Telephone Numb	ber		
	,						
Halling Address ()	Number and Street or P.O. Box Number)						
Mailing Address (r	Number and Street of P.O. box Number)		City		State	Zip Code	
Mailing Address (r	Number and Street of P.O. Box Number)		City		State	Zip Code	
	Program ID Number(s) (Required)		City	Beginning Date (of Training
	Program ID Number(s) (Required)		City	Beginning Date (of Training
California Training Nurse Assistant:	Program ID Number(5) (Required) Home Health	ı Alde:		Beginning Date (of Training
California Training Nurse Assistant:	Program ID Number(s) (Required)	ı Alde:NG. (See C on	the reverse.)		of Training	End Date	
California Training Nurse Assistant: Check here	Program ID Number(s) (Required) Home Health e if you have EQUIVALENT TRAINING for you are requesting RECIPROCIT	n Alde: NG. (See C on Y FROM ANO	the reverse.) THER STATE.	State:	of Training	End Date	reverse.)
California Training Nurse Assistant Check here Check here NAME AND ADI a name change,	Program ID Number(6) (Required) Home Health e if you have EQUIVALENT TRAINING f you are requesting RECIPROCIT DRESS CHANGES: Certificate hole, submit legal verification of the change.	n Alde: NG. (See C on Y FROM ANO ders shall notif ge (marriage c	the reverse.) THER STATE. y CDPH within sixty (60 ertificate, divorce decre	State:	of Training (See	End Date e D on the	reverse.) u have had
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This form is available on our website at: www.cdoh.ca.gov

OBTAINING YOUR FINGERPRINTS IN CALIFORNIA

You must obtain a criminal record clearance in order to receive a CNA certificate. You must complete the Live Scan fingerprint process <u>in</u> <u>California</u> by visiting a Live Scan Agency (Police Department, Sheriff Department, Fed Ex, USPS, We Print, Etc.).





REQUEST FOR LIVE SCAN SERVICE (BCIA 8016) FORM

You must complete all areas indicated in yellow. The Live Scan Agency will complete the bottom half (see example on next page).



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission				
CRI (Code swigned by ECU)		— житютzеа Аррісапт туре		
Type of License/Certification/Permi	LOR Working Tille (Namum 3) char	acters - Feesigrad by 1331, use exact tile assigned)		
Contributing Agency Information	1:			
Agency Authorized to Receive Criminal	Record Information	Mail Code (five-digit code assigned by	DOJ)	_
Street Address or P.O. Bux		Contact Name (mandatory for all school	(эципьышь)	=
City	State ZIP Code	Contact Telephone Number		
Applicant Information:				
Lasi Name		First Name	Middle Intia	Suffix
Other Name				
(AKA or Alas) LeeL		Misi		Sulla
Cate of Brith Sex	Nale Female	Erfver's License Number		
West Wast	and the second	Elling		
Feight Weight	Eye Color Hair Color	Number (Agino BilingNumber)		
Flace or Birth (State or Country)	Social Security Number	Nise. Number	500	
		(Other identification Number)		
Address Street Address or P.C. Box		Сну	Stale ZIP Co	ode
Your Number.		Level of Service: DOJ	_ FBI	
OCA Number (Agency	y identifying Number)			
f re-submission, list original ATI Must provide proof of rejection)		Original ATI Number		
Employer (Additional response)	for agencies specified by stat	ute):		
Employer Name		Mail Code (five digit code assigned by	DOJ)	
Street Address or P.O. Dox		0 -		
сну	State 7P Onde	Telephone Number (optional)		
Live Scan Transaction Complete	ed By:			
Name of Operator		Date		
Fransmitting Agency	LSD	ATI Number	Amount Collected/Billed	

REQUEST **FOR LIVE** SCAN SERVICE SAMPLE (BCIA 8016 SAMPLE)



S' ATE OF CALIFORNIA

DEPARTMENT OF JUSTICE

SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES

REQUEST FOR LIVE SCAN SERVICE

A1226	Certification
ORI (Code assigned by DOJ)	Authorized Applicant Type
Certified Nurse Assistant (CNA) or Home Health Aid	e (HHA)
Type of License/Certification/Permit OR Working Title (Max	inum 30 characters - F assumed by DO I use assure the performed.
Contributing Agency Information:	the state of the s
California Department of Public Health (CDPH)	03314
Agency Authorized to Receive Criminal Record Information	Mail Code (five-digit code pasigned by DOL)
MS 3301, P.O. Box 997416	(Leave blank)
Street Address or P.O. Box	Contact Name (mandatory for all school submissions)
Sacramento CA 95899-741	
City State Zip Code	Contact Telephone Number
Applicant Information:	
Your last name	Your first name & middle initial
Last Name	First Name Middle Initial Suffix
Other Name Other last names known as	Other first names known as
(AKA or Alies) Last (Check one)	First Name Suff x
Date of Birth Sec: Male Female	California Driver's License Number
Date of Birth Height Weight Color Color	Driver's License Number
The state of the s	Billing Not Applicable
Height Weight Eye Color Hair Colo Place of Birth "Social Security Number (Required by	(Aderics annual Kornops)
Plans of Birth (State or Country) Social Security Number	Misc. Tear terepriene names
1	Number (Other Identification Number)
Your mailton address	
Address Street Address or P.O. 30x	City Stala Zip Code
Address Street Address or P.O. 3ox Your Number: *Social Security Number (Required by CDI	City State Zip Code
Address Street Address or P.O. 3ox Your Number: *Social Security Number (Required by CD) OCA Number (Agoncy Identification Number)	City Stain Zip Code
Address Street Address or P.O. 3ox Your Number: *Social Security Number (Required by CDI OCA Number (Agency Identification Number) fine-submission, list ATI number:	City State Zip Code PH) Level of Service: # DO
Address Street Address or P.O. 3ox Your Number: *Social Security Number (Required by CDI	City Stain Zip Code
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NOTE TO APPLICANT: *Flease input your Social Security Number (SSN) where required. The submission of your SSN will allow results to be transmitted from DOJ to CDPH accurately and timely. Failure to submit your SSN could cause delay in your certification



OUT-OF-STATE CERTIFICATE

You must submit a copy of your Out-of-State CNA certificate as proof that you hold an active certificate in the state you wish to transfer from.



PROOF OF WORK

If initial certification was received more than two (2) years ago, you must submit proof of work (paystub or W2) to show you have provided nursing or nursing-related services in a facility to residents for compensation under the supervision of a licensed health professional within the last two (2) years

VERIFICATION OF CURRENT CERTIFICATION

In order to verify your Out-of-State certificate, you must complete the Verification of Current Nurse Assistant Certification (CDPH 931) Form. You will complete Part I of the form with your information, and then send the form to the state in which you currently hold the CNA certificate. Your endorsing state will complete Part II of the form and submit it to our department.

VERIFICATION OF CURRENT **NURSE ASSISTANT CERTIFICATION** (CDPH 931) **FORM**

State of California - Health and Human Services Agency

California Department of Public Health (CDPH) Licensing and Certification Program (L&C) Aids and Technician Certification Section (ATCS) MS 3301 P.O. Box 997416 Sacramento, CA 95899-7416 (916) 327-2455 FAX (916) 552-8785

cne@cdph.ce.gov

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

La	st name:	First	t name:		М	l:		
Sc	ocial Security Number:	Date of birth: (Month	h/Day/Year)	Telephone n	umber:			
Ma	iling address: (Number and Street N	ime or P.O. Box Number)	City	_ r	State		ZIP a	ode
Or	iginally certified under the last	name of:	First			M		
Or	riginal certificate number:	Original date of cer	rtification:	Date last prassistant du		rtified nurse		
	RT II-Must be complete ust be mailed directly by	Agency to CDF	PH. (See ad	dress above.	.)			
1.	This individual is listed on the No Title 42, Code of Federal Regula				irements p	ursuant to	Yes	No
	Certification Number:	Ехр	oires:	Da	ite of Issue	Ε		
	Method of Certification (Check a	ill that apply):						
	☐ Certified by reciprocity from	the state of:				_		
	Completed a state-approve					-		
	Passed a state-administere		ion (i.e. examina	tion) on what date	e: (mm/d	d/yy)		
	☐ Not Available (please expla	-						
3.	Is there documentation of substa (If yes, please attach explanation		t or misappropria	tion of resident pr	operty by t	this individual	? Yes	No
l.	Is there documentation of a felo	•	t of law? (If yes,	please attach exp	lanation.)		Yes	No
i.	Disciplinary Status: None	Revoked	☐ Denied ☐	Suspension				
he	reby certified that the above fac	ts are stated from of	ficial records p	ertaining to this i	ndividual	in the office	of the u	ınders
			Name			Title		
_								
e			Agency					
2	STATE		Address					
2	STATE SEAL		·		State	Zip Cod	le	

CDPH 931 (07/11) This form is available on our website at: www.cdph.ca.gov

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION (CDPH 931) SAMPLE FORM

You must complete all areas indicated in yellow and submit the form to the state you wish to transfer from.

State of California Health and Human Services Agency

SAMPLE

California Department of Public Health(ODP) Llomaing and Certification Program (LSC) Aids and Technician Certification Section (AI MS 3501 P.O. Box 997416 Secremento, CA 95899-7416 (1916) 327-345 FAX (1916) 952-8785

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

lalling a	ecurity Number address: (Number by certified under certificate number	nnd Street Nam	Date of hirth: (Mr. e or P.O. Box Number) me ot: Original date of o	, Ch	rst	Tel (ephone n	umber:	M	ZIP d	ode
alling a	ddress: (Number	nnd Street Nam	e or P.O. Box Number(, Ch	rst	Tel)		M	ZIP o	ode
Inginal Original	y certified unde	r the last na	ime of:	H	rst)	state	M	ZIP o	ode
Original	y certified unde	r the last na	ime of:	H	rst			State	I,4T	ZIP o	ode
Original									М		
Original									М		
Original									Nat		
	oertificate num	ber:	Original date of	sertificati							
	ocrunoate num	per:	Original date of o	certificat							
ART					ertification: Date last provided assistant duties:				rtified nurse		
ART											
ART I											
	II-Must be co	mpleted	by state age	ency fr	om w	rhich ap	plican	t holds (active ce	rtificat	ion 6
iust b	e mailed dir	ectly by	Agency to Cl	DPH. (See a	iddress	above	.)			
. This	ndividual is listed	on the Nors	e Aide Registry a	md has m	et all o	devant Fe	leral reco	irements o	ursuant lo	Yes	No
			ons (42 CFR), Sec								
Certi	fication Number:			Expires:				ate of Issue			
. Meth	od of Certification	(Check all	that apply c								
	Certified by recip	racity from t	he state of						_		
	Completed a stat	e approved	raining program	of (specify	numb	er of hour):		_		
	Passed a state-a	dministered	competency evalu	uaton (i.e	. exam	ination) or	what dat	e: (mm/d	dyy)		
	Not Available (pl	ease explain):								
. Is the	ere documentation	of substant	fated abuse, negl	lect or mis	appro	oriation of	esident p	roperty by t	this individua	l? Yes	No
	s, please attach e										
. Is the	ere documentatio	n of a felony	oonviction in a co	ourt of law	? (If yo	s, please	attaoh ex	olanation.)		Yes	No
Disc	plinary Status:	None	Revoked	□De	nied	Susper	nsion				

CDFH 931 (87/11) This form is available on our webste at: www.cdph.ca.gov

CONTACT INFORMATION

Mailing Address:

California Department of Public Health
Aide and Technician Certification Section
MS 3301
P.O. BOX 997416
Sacramento, CA 95899-7416

Telephone Number: Fax Number:

(916) 327-2445 (916) 552-8785

Website: www.cdph.ca.gov

Email: cna@cdph.ca.gov

CDPH WEBSITE INFORMATION



Helpful Links



Here is the link to the Initial Application (CDPH 283B):

http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph283b.pdf

Here is the link to the Request for Live Scan Service (BCIA 8016):

http://ag.ca.gov/fingerprints/forms/BCIA 8016.pdf

Here is the link to the Request for Live Scan Service Sample (BCIA 8016 Sample):

http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/bcia8016sample.pdf

Here is a link to the Verification of Current Nurse Assistant Certification (CDPH 931):

http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph931.pdf