California Department of Public Health

CDPH

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

REQUIREMENTS

- Submit a completed Initial Application (CDPH 283 B)

- 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

- Submit a copy of your active Out-of-State Certified Nurse Assistant (CNA) certificate**

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)

INITIAL APPLICATION

CDPH 283B

State of California- Health and Human Services Agency

California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
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 FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

Last Name	First Name	MI	Sex
			☐ Male ☐ Female

Address (Number and Street or P.O. Box Number)	City	State	Zip Code

Date of Birth	*Social Security Number (SSN)	Driver's License or State ID Number	Telephone Number
	___ ___ ___ - ___ ___ - ___ ___ ___ ___	Number: _____ State: _____	
Height	**Weight**	**Hair Color**	**Eye Color**

**If you use an invalid SSN, your application will not be processed.*

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7). Yes ☐ No ☐
   - If yes, list conviction:_____ Court of conviction:_____ Date:_____

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you? Yes ☐ No ☐
   - If yes, indicate the type and number of license/certificate:_____

TYPE OF REQUEST *(See **A** or **B** on the reverse.)*

☐ Check here if you are enrolling in a CNA training program and complete the school portion below.
☐ Check here if you are enrolling in a HHA training program and complete the school portion below.

Name of School or Facility Where you Received / Will Receive the CNA or HHA Training		Telephone Number	
Mailing Address (Number and Street or P.O. Box Number)	**City**	**State**	**Zip Code**
California Training Program ID Number(s) (Required)		**Beginning Date of Training**	**End Date of Training**
Nurse Assistant:_____ Home Health Aide:_____			

☐ Check here if you have **EQUIVALENT TRAINING**. *(See **C** on the reverse.)*
☐ Check here if you are requesting **RECIPROCITY FROM ANOTHER STATE**. State:_____ *(See **D** on the reverse.)*

NAME AND ADDRESS CHANGES: Certificate holders shall notify CDPH within sixty (60) days of any change of address. If you have had a name change, submit legal verification of the change (marriage certificate, divorce decree, or court documents). Failure to report a name or address change may result in the delay or loss of your certification.

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

_____ _____
Signature of Applicant Date

TO BE COMPLETED BY THE REGISTERED NURSE (RN) RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM: I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (this section only applies to students that have recently completed a CNA Training Program in California).

FOR VENDOR USE ONLY

_____ _____
Printed Name Title

_____ _____
Signature Date

INITIAL APPLICATION (CDPH 283 B) SAMPLE

You must complete all areas indicated in yellow

State of California- Health and Human Services Agency

SAMPLE

California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
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 FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

Last Name	First Name	MI	Sex
			☐ Male ☐ Female

Address (Number and Street or P.O. Box Number)	City	State	Zip Code

Date of Birth	*Social Security Number (SSN)	Driver's License or State ID Number	Telephone Number
	___ ___ ___ - ___ ___ - ___ ___ ___ ___	Number: _____ State: _____	

Height	Weight	Hair Color	Eye Color

**If you use an invalid SSN, your application will not be processed.*

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7). ☐ Yes ☐ No
   - If yes, list conviction: _____ Court of conviction: _____ Date: _____

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you? ☐ Yes ☐ No
   - If yes, indicate the type and number of license/certificate: _____

TYPE OF REQUEST *(See **A** or **B** on the reverse.)*

☐ Check here if you are enrolling in a CNA training program and complete the school portion below.
☐ Check here if you are enrolling in a HHA training program and complete the school portion below.

Name of School or Facility Where you Received / Will Receive the CNA or HHA Training	Telephone Number

Mailing Address (Number and Street or P.O. Box Number)	City	State	Zip Code

California Training Program ID Number(s) (Required)	Beginning Date of Training	End Date of Training
Nurse Assistant: _____ Home Health Aide: _____		

☐ Check here if you have **EQUIVALENT TRAINING**. *(See **C** on the reverse.)*
☒ Check here if you are requesting **RECIPROCITY FROM ANOTHER STATE**. State: _____ *(See **D** on the reverse.)*

NAME AND ADDRESS CHANGES: Certificate holders shall notify CDPH within sixty (60) days of any change of address. If you have had a name change, submit legal verification of the change (marriage certificate, divorce decree, or court documents). Failure to report a name or address change may result in the delay or loss of your certification.

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Signature of Applicant _____ Date _____

TO BE COMPLETED BY THE REGISTERED NURSE (RN) RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM: I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (this section only applies to students that have recently completed a CNA Training Program in California).

Printed Name _____ Title _____

Signature _____ Date _____

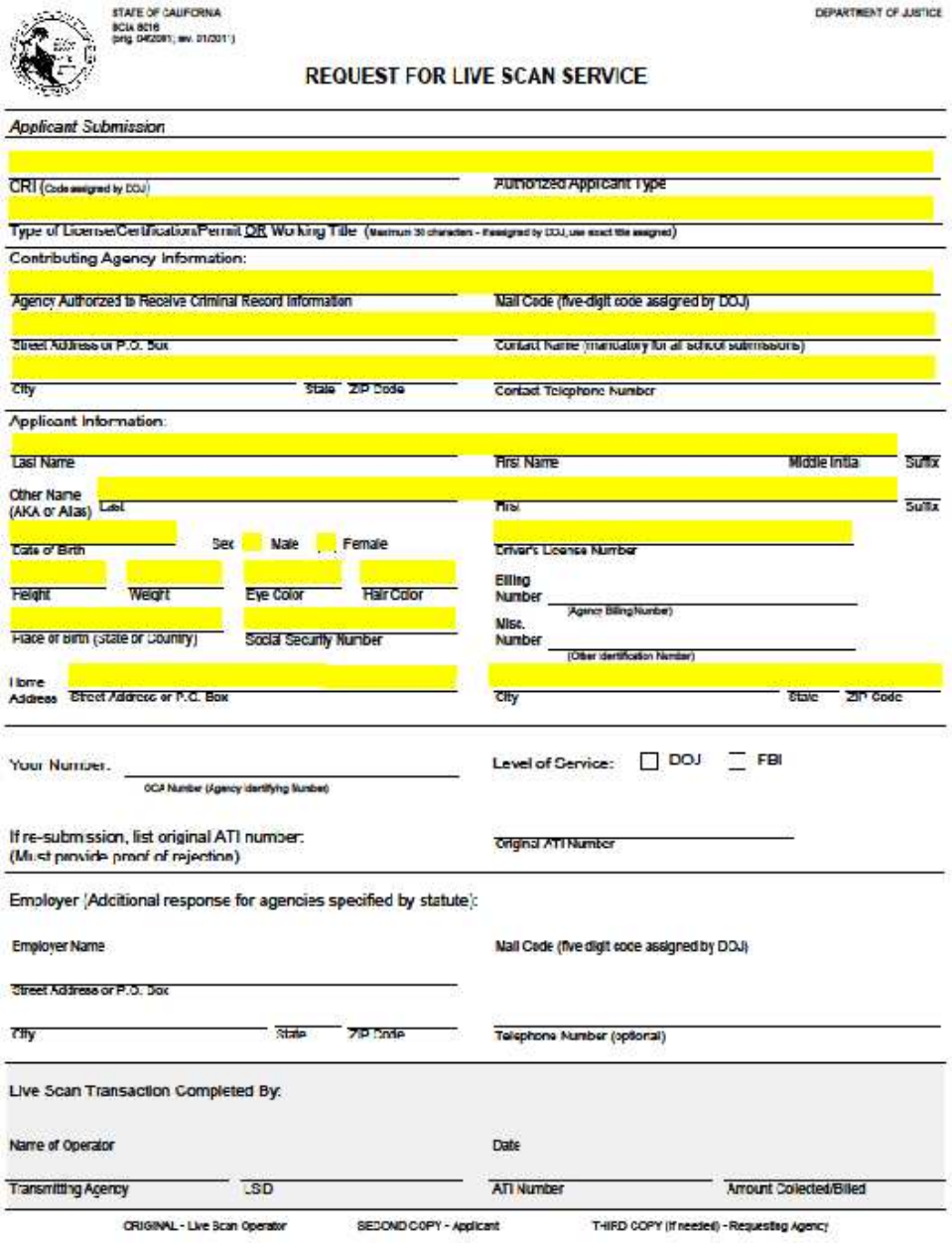
FOR VENDOR USE ONLY

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 **in California** 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).



STATE OF CALIFORNIA
BCIA 8016
(orig. 04/2001, rev. 01/2011)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

CRI (Code assigned by DOJ) | Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information | Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box | Contact Name (mandatory for all school submissions)

City | State | ZIP Code | Contact Telephone Number

Applicant Information:

Last Name | First Name | Middle Initial | Suffix

Other Name (AKA or Alias) | Last | First | Suffix

Date of Birth | Sex ☐ Male ☐ Female | Driver's License Number

Height | Weight | Eye Color | Hair Color | Billing Number (Agency Billing Number)

Place of Birth (State or Country) | Social Security Number | Misc. Number (Other Identification Number)

Home Address | Street Address or P.O. Box | City | State | ZIP Code

Your Number: (OCA Number (Agency Identifying Number)) | Level of Service: ☐ DOJ ☐ FBI

If re-submission, list original ATI number: (Must provide proof of rejection) | Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name | Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City | State | ZIP Code | Telephone Number (optional)

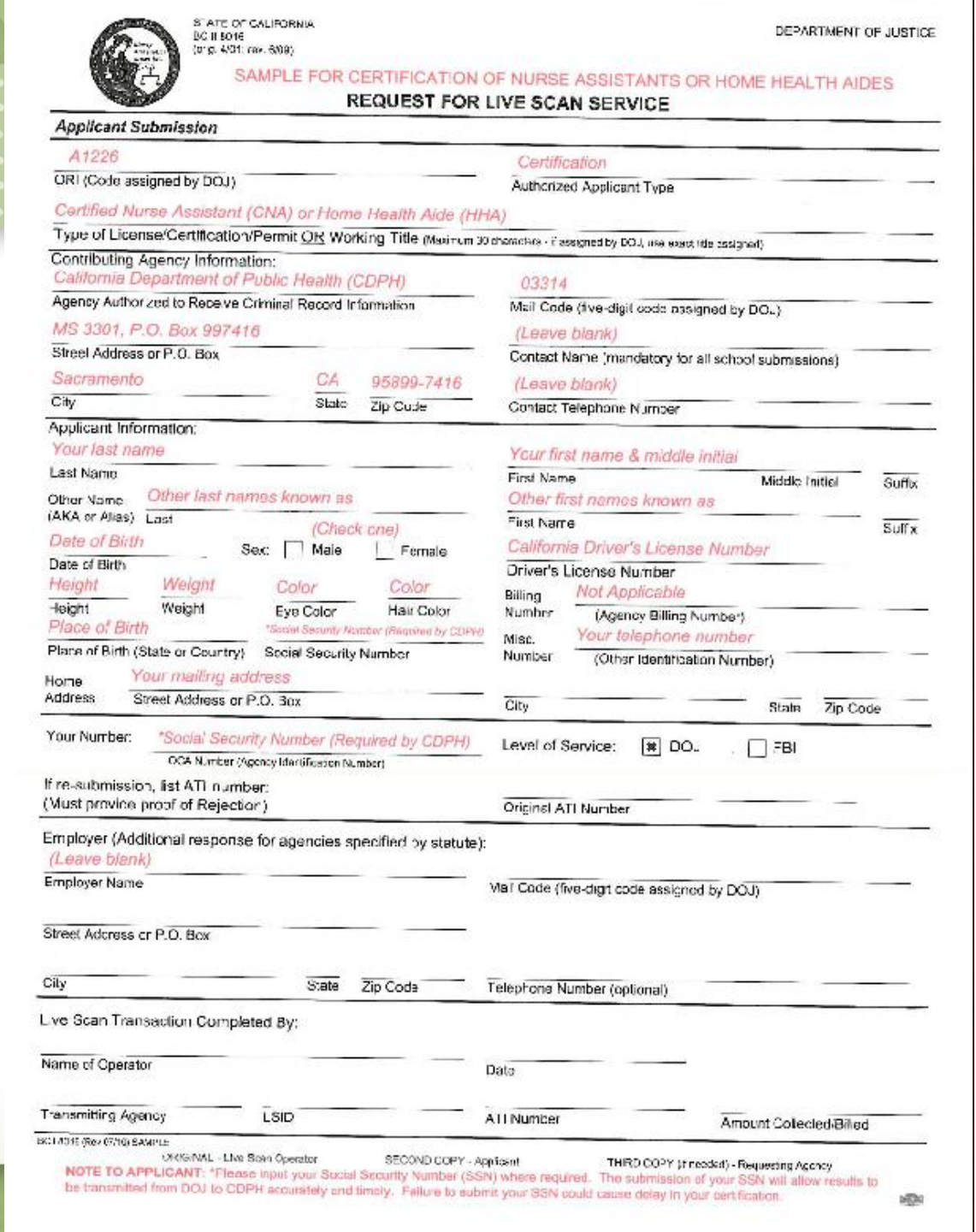
Live Scan Transaction Completed By:

Name of Operator | Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

ORIGINAL - Live Scan Operator | SECOND COPY - Applicant | THIRD COPY (if needed) - Requesting Agency

REQUEST FOR LIVE SCAN SERVICE SAMPLE (BCIA 8016 SAMPLE)



STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 5/09)

DEPARTMENT OF JUSTICE

SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1226 — ORI (Code assigned by DOJ)

Certification — Authorized Applicant Type

Certified Nurse Assistant (CNA) or Home Health Aide (HHA) — Type of License/Certification/Permit OR Working Title (Maximum 30 characters - If assigned by DOJ, use exact title assigned)

Contributing Agency Information:

California Department of Public Health (CDPH) — Agency Authorized to Receive Criminal Record Information

03314 — Mail Code (five-digit code assigned by DOJ)

MS 3301, P.O. Box 997416 — Street Address or P.O. Box

(Leave blank) — Contact Name (mandatory for all school submissions)

Sacramento — City

CA — State

95899-7416 — Zip Code

(Leave blank) — Contact Telephone Number

Applicant Information:

Your last name — Last Name

Your first name & middle initial — First Name / Middle Initial / Suffix

Other Name (AKA or Alias): Other last names known as — Last

Other first names known as — First Name / Suffix

Date of Birth — Date of Birth

(Check one) Sex: ☐ Male ☐ Female

California Driver's License Number — Driver's License Number

Height — Height

Weight — Weight

Color — Eye Color

Color — Hair Color

Billing Number: Not Applicable — (Agency Billing Number)

Place of Birth — Place of Birth (State or Country)

*Social Security Number (Required by CDPH) — Social Security Number

Misc. Number: Your telephone number — (Other Identification Number)

Home Address: Your mailing address — Street Address or P.O. Box

City / State / Zip Code

Your Number: *Social Security Number (Required by CDPH) — OCA Number (Agency Identification Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list ATI number: (Must provide proof of Rejection) — Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank) — Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City / State / Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

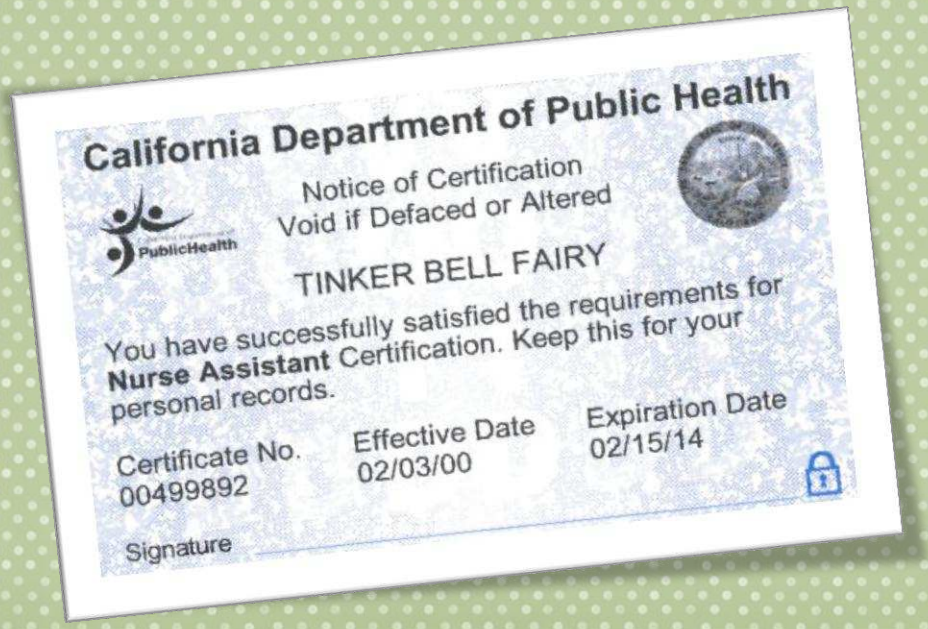
BCII 8016 (Rev 6/10) SAMPLE

ORIGINAL - Live Scan Operator — SECOND COPY - Applicant — THIRD COPY (if needed) - Requesting Agency

NOTE TO APPLICANT: *Please 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.

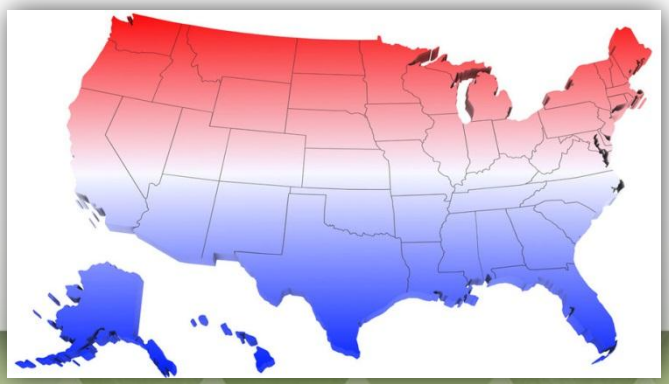


PROOF OF WORK

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)
Aide and Technician Certification Section (ATCS)
MS 3301
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 327-2445 FAX (916) 552-8785
cna@cdph.ca.gov

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

PART I-To be completed by the applicant. Please PRINT clearly or TYPE.

Last name:	First name:	MI:
*Social Security Number:	Date of birth: *(Month/Day/Year)*	Telephone number: ( )
Mailing address: *(Number and Street Name or P.O. Box Number)*	*City*	*State* / *ZIP code*
Originally certified under the last name of:	*First*	*MI*
Original certificate number:	Original date of certification:	Date last provided certified nurse assistant duties:

PART II-Must be completed by state agency from which applicant holds active certification and must be mailed directly by Agency to CDPH. (See address above.)

1. This individual is listed on the Nurse Aide Registry and has met all relevant Federal requirements pursuant to Title 42, Code of Federal Regulations (42 CFR), Sections 483.75, 483.150-483.156. Yes ☐ No ☐
   Certification Number: _____ Expires: _____ Date of Issue: _____
2. Method of Certification (Check all that apply):
   - ☐ Certified by reciprocity from the state of: _____
   - ☐ Completed a state-approved training program of (specify number of hours): _____
   - ☐ Passed a state-administered competency evaluation (i.e. examination) on what date: (mm/dd/yy) _____
   - ☐ Not Available (please explain): _____
3. Is there documentation of substantiated abuse, neglect or misappropriation of resident property by this individual? (If yes, please attach explanation.) Yes ☐ No ☐
4. Is there documentation of a felony conviction in a court of law? (If yes, please attach explanation.) Yes ☐ No ☐
5. Disciplinary Status: ☐ None ☐ Revoked ☐ Denied ☐ Suspension

It is hereby certified that the above facts are stated from official records pertaining to this individual in the office of the undersigned.

Date _____

STATE SEAL

Name _____ Title _____

Agency _____

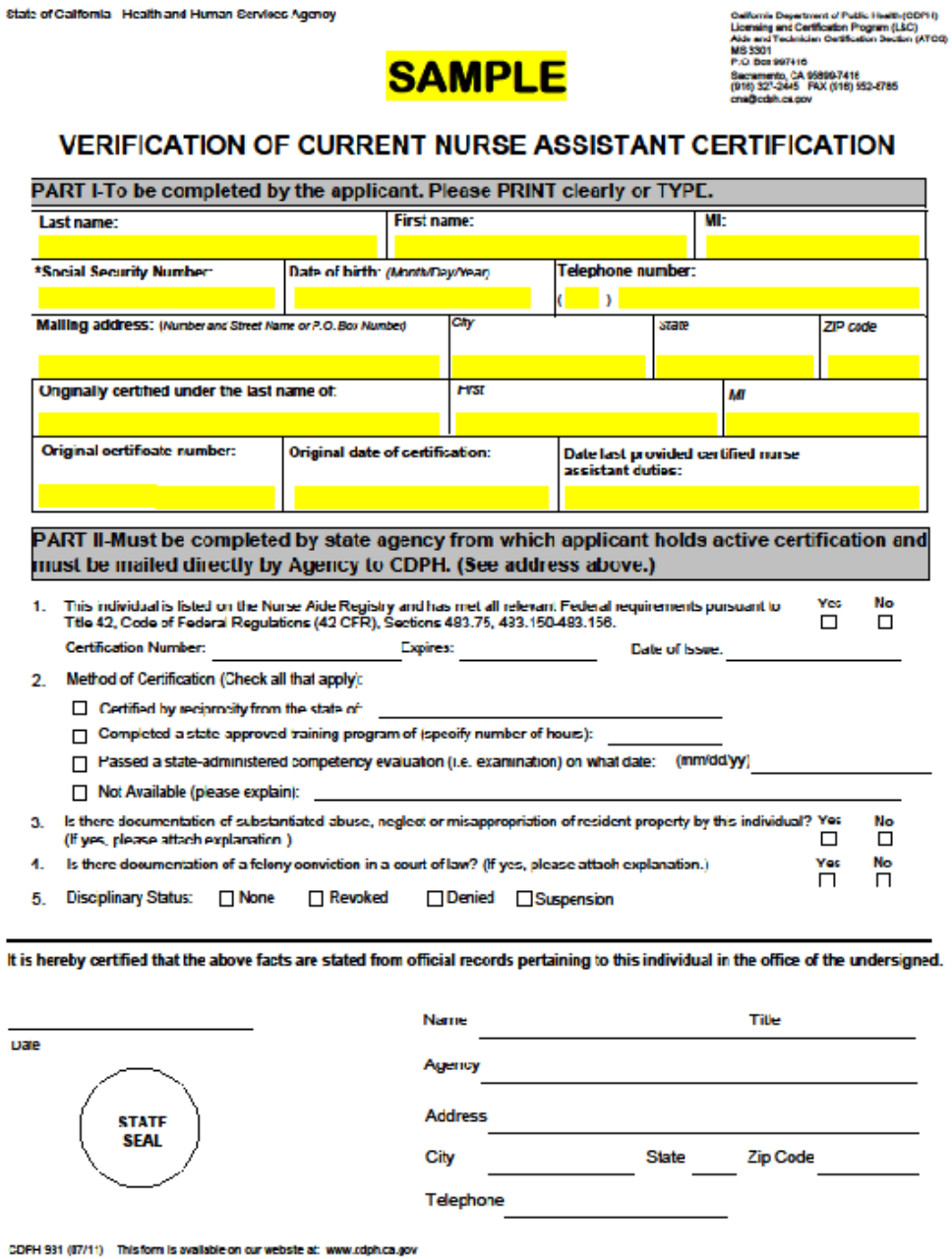
Address _____

City _____ State _____ Zip Code _____

Telephone _____

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 (CDPH)
Licensing and Certification Program (LSC)
Aide and Technician Certification Section (ATCS)
MS 3301
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 327-2445 FAX (916) 552-8785
cna@cdph.ca.gov

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

PART I-To be completed by the applicant. Please PRINT clearly or TYPE.

Last name:	First name:	MI:

*Social Security Number:	Date of birth: (Month/Day/Year)	Telephone number:
		( )

Mailing address: (Number and Street Name or P.O. Box Number)	City	State	ZIP code

Originally certified under the last name of:	First	MI

Original certificate number:	Original date of certification:	Date last provided certified nurse assistant duties:

PART II-Must be completed by state agency from which applicant holds active certification and must be mailed directly by Agency to CDPH. (See address above.)

1. This individual is listed on the Nurse Aide Registry and has met all relevant Federal requirements pursuant to Title 42, Code of Federal Regulations (42 CFR), Sections 483.75, 483.150-483.156. Yes ☐ No ☐
   Certification Number: _____ Expires: _____ Date of Issue: _____
2. Method of Certification (Check all that apply):
   - ☐ Certified by reciprocity from the state of: _____
   - ☐ Completed a state approved training program of (specify number of hours): _____
   - ☐ Passed a state-administered competency evaluation (i.e. examination) on what date: (mm/dd/yy) _____
   - ☐ Not Available (please explain): _____
3. Is there documentation of substantiated abuse, neglect or misappropriation of resident property by this individual? Yes ☐ No ☐
   (If yes, please attach explanation.)
4. Is there documentation of a felony conviction in a court of law? (If yes, please attach explanation.) Yes ☐ No ☐
5. Disciplinary Status: ☐ None ☐ Revoked ☐ Denied ☐ Suspension

It is hereby certified that the above facts are stated from official records pertaining to this individual in the office of the undersigned.

Date _____

STATE SEAL

Name _____ Title _____

Agency _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

CDPH 931 (07/11) This form is available on our website 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:
(916) 327-2445

Fax Number:
(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