FOR OFFICE USE ONLY	
☐ PW _____	☐ PP _____
☐ FW _____	☐ FP _____
☐ FW _____	☐ FP _____
☐ FW _____	☐ FP _____
Receipt #	
ID #	
Issue Date	
License #	

Instructions and Application For

License As A Nursing Assistant

- ☐ By Examination (RI Nursing Assistant Training Program)
- ☐ By Examination (Nursing Student)
- ☐ By RN or LPN License
- ☐ By Endorsement (100 Training Program Hours)
- ☐ By Endorsement (3 Months Full-Time Employment)

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

DO NOT REMOVE THIS PAGE FROM APPLICATION

DO NOT HAND DELIVER - APPLICATION MUST BE MAILED

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555**

GENERAL INFORMATION

Enclosures

The following information is enclosed:

Military Expedited

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Statute

Chapter 23-17.9 entitled “Registration of Nursing Assistants” can be downloaded at the following website:

http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm

Rules and Regulations

To obtain the Rules and Regulations for your profession, visit the following web site. From the list, click on your profession.

http://www.health.ri.gov/licenses/

Competency Examination

The Training Program Coordinator will schedule your test after you successfully complete the Nursing Assistant training program.

You will be given three opportunities to successfully complete the Nursing Assistant examinations. If you fail to give prior notice and do not arrive to take a scheduled test, it will count as a failed attempt. You may be employed as a trainee for 120 days. You must complete the testing process within one (1) year from the date you began the training program or you will be required to complete a new application and pay all fees.

Initial License

Once you have passed your examinations, you will be notified. Your license may expire within a few months up to two years after your examination. You may need to renew your license prior to the normal two-year expiration period. Expiration dates are June 30th.

GENERAL INFORMATION (CONTINUED)

Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to your license expiration date. You must obtain the signature of an official in a **licensed Rhode Island health care facility ONLY** (i.e. nursing home) where you were employed as a Nursing Assistant within the 24 months prior to renewal. **If you document that you were working in a facility other than a licensed Rhode Island health care facility, you will not be eligible for renewal. YOUR LICENSE MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER.**

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, 3 Capitol Hill, Room 104, Providence, RI 02908.

Application Process

You must submit the application and additional information. All items listed on the following applicable checklist must be submitted for an application to be considered complete. **APPLICATIONS ARE ONLY VALID FOR A ONE (1) YEAR PERIOD.**

Please allow a minimum of 8 weeks for the entire licensure process to be completed.

If you previously had a license as a Nursing Assistant in Rhode Island, there are two ways to reinstate your license:

1. You must retrain and retest with a Rhode Island Nursing Assistant Training Program and follow the application instructions by Examination.

   Or

2. You are currently licensed in another state as a Nursing Assistant and must follow the application instructions by Endorsement.

You are responsible for notifying HEALTH, in writing, when your address changes.

Once completed, the application will be reviewed and you will be contacted in writing. NOTE: You may ***not*** practice as a Nursing Assistant in Rhode Island until you have received your license.

To obtain your licensure status and license number, please refer to the HEALTH Licensee Lookup website:

https://healthri.mylicense.com/Verification/

If you have any questions about the application process, please contact this office at (401) 222-5888.

120 Day Temporary Permit

Applicants for Licensure by Examinaton will be given a temporary permit for 120 days. No extensions will be granted.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Read the following instructions carefully before you complete the application. **Only completed applications will be accepted.** Failure to submit all required information, appropriate documentation and required fee will result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Illegible information will not be accepted.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. Make a copy of your completed application before you submit it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application. You must respond to all sections of the application as instructed. If you attach separate pages as a continuation of the application, please clearly indicate the section for which such information is being reported.
2. Make a check or money order payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first page of the application. The application fee is NON-REFUNDABLE.
3. Do not submit the application without all applicable information, documentation and fee. Mail the application to:

Rhode Island Department of Health
3 Capitol Hill, Room 104 - NA Board
Providence, RI 02908-5097

APPLICATION CHECKLISTS

Please review the following checklists, **choose which one applies to you**, and include all of the required information to complete your Nursing Assistant application.

All applicants must include the following:

By Examination (If you are in a licensed Rhode Island Nursing Assistant Training Program)

1. A $35.00 non-refundable fee made payable to RI General Treasurer;
2. Completion of Department licensed Rhode Island Nursing Assistant Training Program;
3. A passport-type 2 x 3 inch photograph, taken within 1 year;
4. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
5. Completed and notarized application; and
6. Completion of written and practical Nursing Assistant examinations, within 1 year from the date you began the training program (given 3 opportunities to complete);

By Examination- Nursing Students (If you are a nursing student in a nursing program and completed 2 clinical nursing program courses)

1. A $35.00 non-refundable fee made payable to RI General Treasurer;
2. Official transcript or signature of Dean of the School of Nursing;
3. A passport-type 2 x 3 inch photograph, taken within 1 year;
4. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
5. Completed and notarized application; and
6. Completion of written and practical Nursing Assistant examinations, within 1 year from the date you began the training program (given 3 opportunities to complete);

By RN or LPN License (If you are licensed as a RN or LPN in good standing)

1. A $35.00 non-refundable fee made payable to RI General Treasurer;
2. Verification of current RN or LPN license;
3. A passport-type 2 x 3 inch photograph, taken within 1 year;
4. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
5. Completed and notarized application; and

By Endorsement (If you have an Active license in good standing as a Nursing Assistant in another state and want to be licensed in RI)

1. A $35.00 non-refundable fee made payable to RI General Treasurer;
2. A passport-type 2 x 3 inch photograph, taken within 1 year;
3. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
4. Completed and notarized application;
5. Evidence of a current license as a Nursing Assistant in another state
   (Completed Interstate Verification Form - Page 10)
   You must complete the top section of the form and send the form to the other state board; and
6. Evidence of Nursing Assistant Training Program Hours **OR** Evidence of Employment as a Nursing Assistant

   Evidence of 100 Training Program Hours
   A copy of your Nursing Assistant Training Program Certificate or letter on company letterhead, which states both the number of written training hours **AND** the number of skills training hours.

   OR

   Evidence of 3 Months Employment
   If your Nursing Assistant Training Program was less than 100 hours, you must provide an employer's statement that you have at least 3 months of full-time work experience within the last year as a Nursing Assistant
   (Completed Employment Verification Form - Page 11)
   You must complete the top section of the form and send the form to your employer

State of Rhode Island

Application for License as a Nursing Assistant

1. Name(s)

This is the name that will appear on the HEALTH website. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify HEALTH of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify HEALTH of all address changes.

This address will appear on the Health website.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

Applicant: Print your complete last name >

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address.

☐ Please use my **Business Address** as my preferred mailing address.

8A.Rhode Island Nursing Assistant Training Program Information

STOP!
FOR RI EXAMINATION APPLICATIONS ONLY

Please list the name and information about the training that you participated in that qualifies you for this license.

Signature Required

Name of School/Training Program

Address (Number and Street)

City | State | Zip Code

License Number of School/Training Program:

Date Class Began: Month Day Year

Date Graduated Month Day Year

Test Site:

Employment Date: (If Applicable) Month Day Year

Test Date: Month Day Year

EXAMINATION APPLICANTS - Provide Signature of Training Program Coordinator.

Signature | Title | Date

Print or Type Name | Phone

8B.Nursing Student Information

STOP!
FOR NURSING STUDENT APPLICATIONS ONLY

Please list the name and information about the training that you participated in that qualifies you for this license.

Signature Required

Type of School (University, College, Trade/Technical School etc.)

Name of School/Training Program

Date of Completion of Qualifying Clinical Training: Month Day Year

NURSING STUDENT APPLICANTS - Provide Signature (and Title) of School of Nursing Dean (or Designee).

*My signature below indicates and attests to the fact that the Nursing Student who has made this application to the Nursing Assistant Advisory Board has **completed a minimum of two (2) clinical courses**.*

Signature | Title | Date

Print or Type Name | Phone

Rhode Island Nursing Assistant Testing Information

You are required to successfully complete a written and practical examination to become licensed as a Nursing Assistant. Please review the Rhode Island Nursing Assistant Candidate Handbook, dated July 2011.

PLEASE CALL CCRI's Lincoln Campus at (401) 333-7077 to schedule your examination.

9. Original and Other State License Information

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If you answered ***"yes"***, list the license number(s) of the original state (and any other states) of licensure below:

Original Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

10. Criminal Convictions

If needed, you may continue on a separate sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? **If you answer yes and do <u>not</u> provide a detailed explanation, your application will not be processed.** ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

Month | Year

11. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes", you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, you may continue on a separate sheet of paper.

12. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

I _____ being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Nursing Assistant in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant Date of Signature (MM/DD/YY)

The foregoing application was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did take an oath.

_____ _____

Name of Notary (Print, Type or Stamp) Signature of Notary

Notary Seal

_____ _____

Notary No/Commission No. Commission Expiration Date (MM/DD/YY)

13. Recent Photograph

Securely tape or glue a passport type 2" x 3" photograph.

NO PHOTOCOPIES

ATTACH WITH CLEAR TAPE ONLY

Provide the date that the photograph was taken.

_____

Date of Photograph

Rhode Island Department of Health
3 Capitol Hill, Room 104
Providence, RI 02908-5097
(401) 222-5888

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for reinstatement to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Department of Health requires that this form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO THE OTHER STATE BOARD

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE NURSING ASSISTANT BOARD

Directions for State Board: Please complete and return this form to the address above. *Please verify requirements met in your state.*
If you answer "yes" to any of the questions, please explain on a separate sheet of paper and attach it to this form.

Licensed by Examination? ☐ Yes ☐ No
If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Explain)

Applicant has completed and passed the National Certification Exam: ☐ Yes ☐ No Score_____ Level of Exam:_____

License Status: ☐ Active ☐ Inactive ☐ Lapsed

Original Date Issued: _____

Expiration Date: _____

Questions:

1. Has this applicant met all relevant state and federal requirements under OBRA '87 and '89 for Nursing Assistant Registration in the state of_____? ☐ Yes ☐ No
2. Please indicate method and state approved training program_____in the state of_____
   Date of Completion_____Number of hours_____
3. Competency Evaluation in state of_____ Date of Completion_____OR Reciprocity/Endorsement
   Registration in state of _____ Other method (please explain):_____
4. Registration Number_____Issued_____Expiration_____
5. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
6. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
7. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
8. Do you know of any information that may discredit this person? ☐ Yes ☐ No

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the above address. Thank you for your prompt cooperation.

Rhode Island Department of Health
3 Capitol Hill, Room 104
Providence, RI 02908-5097
(401) 222-5888

NURSING ASSISTANT VERIFICATION OF EMPLOYMENT FORM

I am applying for a license to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Department of Health requires that applicants for Rhode Island licensure must have this form verified and signed by their Employer/Employing Agency. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO EMPLOYER

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER/EMPLOYING AGENCY

The individual named above has made application to the Rhode Island Department of Health to become a Nursing Assistant.

☐ This is to certify that _____has completed three (3) months of full-time work experience as a Nursing Assistant.

Name of Employer/Employing Agency:_____

Address:: _____

City, State, Zip Code: _____

Dates of Employment: From_____ To_____
month/day/year month/day/year

Additional Comments:

_____

_____

Certification:

_____ _____
Signature of Administrator/DNS Date

_____ _____
Type or Print Name Title

Acknowledgement:

By signing this form,I hereby affirm that my comments and answers to the above questions are true and complete to the best of my knowlege

Please return directly to the above address. Thank you for your prompt cooperation.