Nursing Assistant Certification Endorsement Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Nursing Assistant Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3: Caregiver Employment History**
List the last place of caregiver employment with its address, the first and last days of employment, and the last two states where your name appears on the OBRA registry.

☐ **4: Program Director Attestation Not Required for Interstate Endorsement:**
Have the Program Director complete this section or attach a copy of your training certificate. Not required for Interstate Endorsement application.

☐ **5: Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current. Attach additional completed pages if you need more space.

☐ **6: AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **7: Applicant's Attestation:**
You must sign and date this for us to process the application.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application

Instructions for Current and Former Servicemembers Requesting Evaluation of Military Training and Experience Toward Meeting Washington Credentialing Requirements

The Department of Health licenses health care professionals in accordance with state laws and requirements. Under a new state law passed in 2011, people with military training and experience may count their training and experience towards certain civilian health care profession credentialing requirements if the state determines it is substantially equivalent to the state's standards.

Please complete the additional form found at **the military resources page** and include supporting documentation with your application.

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Certification Requirements

To be eligible to apply for nursing assistant certification you must:

- Submit Application;
- Submit Fee;
- Successfully complete an approved nursing assistant training program or meet the requirements for alternate training;

  A list of approved programs is located at the website below:
  https://fortress.wa.gov/dshs/adsaapps/Professional/nat/search.aspx

  Transcripts: Have your school send official school transcripts directly to Nursing Assistant Credentialing.

- Have completed a cardiopulmonary resuscitation course; and
- Have successfully completed the nurse aide competency evaluation.

Alternative Training

Successful completion of an approved alternative program and the nurse aide competency evaluation may allow the certified home care aide or certified medical assistant to meet the requirements to become a certified nursing assistant.

If you are a certified home care aide seeking nursing assistant-certification, refer to **WAC 246-841-545** alternative program requirements.

If you are a certified medical assistant seeking nursing assistant-certification, refer to **WAC 246-841-550** alternative program requirements.

To become certified as a nursing assistant through alternative training you must meet the following requirements:

- Submit Application;
- Submit Fee;
- Be currently certified as a home care aide under chapter **18.88B RCW**;
  - Provide a copy of certificate of completion from an approved alternative program for certified home care aides.
  - Provide documentation verifying current certification as a home care aide.

OR

- Be a certified medical assistant by a medical assistant program accredited by the Commission on Accreditation and Allied Health Education Programs (CAAHEP) or the American Association of Medical Assistants and the American Medical Association.
  - Provide a copy of certificate of completion from an approved alternative program for certified medical assistant;
  - Provide an official transcript from the nationally accredited medical assistant program;

Transcripts: Have your school send official school transcripts directly to Nursing Assistant Credentialing.

- Have completed a cardiopulmonary resuscitation course; and
- Have successfully completed the nurse aide competency evaluation. Graduates of alternative programs who meet all application requirements are deemed eligible to complete the nurse aide competency evaluation approved by the Nursing Care Quality Assurance Commission.

Instructions for Nursing Assistant Certification by Interstate Endorsement

If your name is listed on another state registry and you hold an active credential in another state, you may qualify for Interstate Endorsement as a Certified Nursing Assistant in Washington State.

You may apply for state certification by completing the following requirements:

1. Application for Nursing Assistant Certification by Interstate Endorsement. Complete Section 1, 2, 3, 5 and 6. Section 4 is not required. Check the correct box for Nursing Assistant Certification by Interstate Endorsement.
2. Complete the top portion of the Out-of-state Verification Form and send it to the state you are coming from. That state will complete the bottom portion of the Verification Form and mail it directly to Washington State. Contact information for other states can be found at: **http://www.adsa.dshs.wa.gov/professional/nat/out%20of%20state%20register%20list.htm#M**.

Other Information

Criminal history checks are conducted for all license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through section instead of leaving blank.
- The initial certification will expire on your birthday unless the initial certification is issued within 90 days of your next birthday.
- A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the nursing assistant program is available on our **Web site.**

Note: You cannot practice as a nursing assistant until your certification is issued.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue 0299030000

Nursing Assistant Certification Endorsement Application

☐ Nursing Assistant Certification by approved Nursing Assistant Program

☐ Nursing Assistant Certification by Interstate Endorsement

☐ Nursing Assistant Certification by Alternative Training Program

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address (if different from above)

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

☐ AIDS ☐ PDQ ☐ Other _____

Certification # _____ Issue Date _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have: a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Caregiver Employment History

Last Place of Caregiver Employment	First/Last Days of Employment

Address of Last Place of Caregiver Employment

List the Last Two States Where Your Name Appears on the OBRA Registry

1._____ 2._____

4. Program Director Attestation (Not Required for Interstate Endorsement)

To be completed by Program Director or attach a copy of your training certificate.

I certify _____ , has successfully completed
Type or Print Full Name of Applicant

the approved nursing assistant program at _____
Name of Facility/School

on _____.
mm/dd/yyyy

Signature _____ Title _____

5. Other License, Certification, or Registration

List all states, including Washington, where any health care credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

State/ jurisdiction	Profession	Certificate		Permanent or Temporary	License Received		Currently in force
		Year	Number		Exam	Other	
				☐ No ☐ Yes			☐ No ☐ Yes
				☐ No ☐ Yes			☐ No ☐ Yes
				☐ No ☐ Yes			☐ No ☐ Yes
				☐ No ☐ Yes			☐ No ☐ Yes

6. AIDS Education and Training Attestation

I certify I have completed a minimum of seven hours of education in the prevention, transmission, and treatment of AIDS. The education was through my professional education or through the completion of DSHS required training for caregivers or staff employed by DDD Certified Residential Programs. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked. **AIDS training may include self study, direct patient care, online courses, or formal training.**

Applicant's initials	Date

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)

the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Original signature of applicant)

Washington State Department of Health
Nursing Assistant Credentialing
PO Box 47877
Olympia, WA 98504.7877
360.236.4700

Out of State Credential Verification Form

Mail this form to the state you are coming from. They will return it to the Washington State Department of Health.

Part I: To Be Completed By Applicant

I am listed on the Nurse Aide Registry in the state of _____ under the name of

_____ and my registration number is _____

Social Security Number _____ Telephone Number _____

Mailing Address _____

☐ I completed a nursing assistant training program at _____ on _____.
Training Site mm/dd/yyyy

☐ I completed a competency examination on _____ .
mm/dd/yyyy

☐ I became a nursing assistant by waiver or deeming.

☐ I am applying in Washington under the name of _____.

Last recorded place of caregiver employment _____.

Starting and ending date of caregiver employment _____
Start Date: mm/dd/yyyy End Date: mm/dd/yyyy

Address _____

Nurse Aide: Do **not** return this form to the Washington Nurse Aide Registry. After you have completed the information requested above, it is your responsibility to send this form to the state agency from which you completed your nurse aide training and testing.

Part II: To Be Completed By State Agency

☐ The information on this form is accurate and the above-named person is on the nursing assistant registry in our state.

☐ The above-named person is not on the nursing assistant registry in our state.

Date of Registration or Certification _____ Number _____
mm/dd/yyyy

Date of Expiration of Registration or Certification _____

Has Registrant had any type of disciplinary action? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

Is Registrant currently under investigation? ☐ Yes ☐ No

Signature _____ Date _____

Title _____ State _____

(This page intentionally left blank.)

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act (UDA)..... RCW 18.130

Administrative Procedure Act (APA)..... RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Nursing Assistants RCW .....RCW 18.88A

Nursing Assistants WAC..... WAC 246-841

Online

AIDS Training Resources ..... Reference Page

Nursing Assistant Program..... Web page

List of State Nursing Registries .....Registries