Delaware Health and Social Services
Division of Health Care Quality
DELAWARE NURSE AIDE APPLICATION FOR CERTIFIED NURSE AIDE RECIPROCITY

GENERAL INFORMATION AND INSTRUCTIONS

PART I: ELIGIBILITY - A nurse aide from another State may apply for certification to the Delaware Nurse Aide Registry in lieu of completing a Delaware State Approved Nurse Aide Training and Competency Evaluation Program by meeting the following qualifications:

1. Must be listed on another State's Nurse Aide Registry as CURRENT or ACTIVE, and in good standing. Must have a Geriatric Nurse Aide (GNA) certification if coming from the State of Maryland.
2. Have no pending or substantiated findings of adult/child abuse, neglect, financial exploitation, and/or misappropriation of resident/patient property recorded on **any** State's Nurse Aide Registry.
3. Have work experience as a Certified Nurse Aide (CNA) [within the last 24-months] for at least three (3) months (full time) or at least 420 hours under the direct supervision of a Nurse or Physician performing nursing related duties for pay. Nursing related duties include but are not limited to the following: bathing, dressing, grooming, toileting, ambulating, transferring, feeding, observing and reporting the general well-being of the person(s) to whom a qualified person is providing care, or
4. Completed Nurse Aide Training at an approved Nurse Aide Training and Competency Evaluation Program (NATCEP).

PART II: INSTRUCTIONS - The following is a detailed checklist of required items:

☐ 1. **Application for Reciprocity*:*** Must be completed by the applicant/CNA. **PLEASE PRINT LEGIBLY;** sign and date the bottom of the page verifying that the information provided is accurate. **ALL** fields must be completed. **Forms with illegible writing or with white out will not be accepted.**

☐ 2. **Employer Verification Form:** To be completed by a current or former employer (within the last 24 months). Verification of employment should include dates of employment, status (FT, PT, or Per Diem), job title, and the total number of hours worked during your tenure. Financial/Salary information is ***not*** required for this verification. Completed form *must* be notarized. W-2's will not be accepted for employment verification. The Division reserves the right to contact the Employer to verify the validity of submitted documentation. **Forms with illegible writing or with white out will not be accepted.**

☐ 3. **Training Program Verification Form:** To be completed by the Training Program Administrator. This verification form should be submitted if the applicant does not have work experience equal to 3-months (full time) or 420-hours. Training must have been completed in a Nurse Aide Training and Competency Evaluation Program (NATCEP). Completed form *must* be notarized. The Division reserves the right to contact the Training Program Administrator to verify the validity of submitted documents. **Forms with illegible writing or with white out will not be accepted.**

☐ 4. Provide verification of current/active State Certification in good standing. Please list *ALL* States in which you have *ever* been certified whether currently active or inactive. You do not need to send verification from any State other than the State from which you are transferring.

GENERAL INFORMATION AND INSTRUCTIONS (CONTINUED)

☐ 5. A *legible* copy of a government issued Photo ID which shows your full [legal] name and your date of birth (preferably a State Driver License/Identification or a Passport).

☐ 6. ***THE SEALED/UNOPENED COPY*** of the National Practitioner Data Base self query. Please visit https://www.npdb.hrsa.gov/ to request a search of your information; there is a cost for this self query. You will be required to submit payment using a credit/debit card. Once your request has been submitted, you will receive both an online response via email, and a sealed copy via US Mail. ***DO NOT OPEN THE ENVELOPE WHEN YOU RECEIVE IT***
This **sealed/unopened** copy should be submitted along with your application and other supporting documents.

☐ 7. The Reciprocity Processing fee is $30; please submit payment along with all other documents. Payment should be in the form of a check or money order, and made payable to: **STATE OF DELAWARE**. Please note that all fees made payable to the State of Delaware are non-refundable if your application is denied for any reason.

Mail or Drop Off Completed Application and All Supporting Documentation and Payment to:

DHSS, Division of Health Care Quality
Attn: CNA Registry/Reciprocity
24 NW Front Street, Suite 100
Milford, Delaware 19963

OR

DHSS, Division of Health Care Quality
Attn: CNA Registry/Reciprocity
263 Chapman Road, Suite 202 Cambridge Bldg.
Newark, Delaware 19702

If you have any questions, please call 302-424-8600 or 302-421-7419

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APPLICATION: TO BE COMPLETED BY NURSE AIDE

Instructions: Type or print (legibly). Your original signature is required; photocopies of this form will not be accepted. Forms with illegible writing or white out will not be accepted.

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____
Applicant's name should match name as it appears on the CNA Registry in your State. If different from Photo ID please provide documentation.
MAILING ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: _____

DAY TIME PHONE #:_____DATE OF BIRTH:_____

EMAIL ADDRESS: _____ GENDER: Male ____Female ____

HAVE YOU EVER BEEN CERTIFIED IN THE STATE OF DELAWARE? YES _____ NO_____
If YES, please provide Certification #: _____ (*Note: If your Delaware Certification lapsed within the past 24-months you may not be eligible for Reciprocity. Please contact our office.)

CURRENT STATE OF CERTIFICATION: _____ CERTIFICATION NUMBER:_____
(Must be GNA if from the State of Maryland) Please attach proof of current/active certification

Please list below *ALL* states in which you have *EVER* been certified whether currently active or inactive:

_____ _____ _____ _____ _____ _____ _____ _____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect, financial exploitation and/or misappropriation of resident/patient property)? **Yes No**
   If NO, you may not be eligible for reciprocity. Please contact our office

2) Have you *EVER* had a negative finding entered against you on *ANY* State registry? **Yes No**
   If YES, give details on a separate sheet of paper.

3) Have you worked in a healthcare setting **within the last 24 months** as a CNA for at least three months or at least 420 hours for pay under the supervision of a Nurse or Physician?
   Yes No
   If you answered YES to this question, please have your employer completed the Employer Verification Form. If you answered NO to this question, please answer question #4.

APPLICATION: TO BE COMPLETED BY NURSE AIDE (CONTINUED)

4) If you have *NOT* worked for pay for at least three months full time and/or at least 420 hours, have you completed a Nurse Aide Training and Competency Evaluation Program (NATCEP).
Yes No
If you answered YES to this question, please have a Training Program Administrator complete the Training Program Administrator Verification Form. If you answered NO to this question, you may not be eligible for reciprocity. Please contact our office.

*I certify that all information provided in this application is true. I understand that my application may be denied for submitting false and/or fraudulent information. If approved, I understand that my Certification is subject to disciplinary action if findings later determine that I committed fraud, misrepresentation, and/or deceit in order to obtain the certification.

Signature of Applicant: _____ Date: _____

Printed Name of Applicant_____

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EMPLOYER VERIFICATION FORM

Applicant's Name: _____DOB: _____

1. **This form is to be completed by the *Employer***. Applicants, please enter *(only)* your name and date of birth above.
2. Forms must be notarized. If there is no licensed notary in the facility, Employers may submit verification on official company letterhead. Please remember that photocopies of this form will *NOT* be accepted. Forms with illegible writing or with white-out will *NOT* be accepted.
3. Please Note: W-2s will *NOT* be accepted as proof of employment. Calls will not be made to *Work Net* or *The Work Number.*

EMPLOYER NAME: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

CONTACT NUMBER: _____

CONTACT EMAIL:_____

Please complete the section below:

AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked

(circle one) FULL TIME or PART TIME

from (mm/dd/yyyy)_____to (mm/dd/yyyy)_____ for pay, for a total of _____ hours, under the supervision of a Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: _____ Signature: _____

Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____

County, In the State of ____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____

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TRAINING PROGRAM ADMINISTRATOR VERIFICATION FORM

Applicant's Name:_____ _____DOB: _____

1. **This form is to be completed by the *NATCEP Administrator***. Applicants please enter *(only)* your name and date of birth above.
2. Forms must be notarized. If there is no licensed notary in the facility, Program Administrators may submit verification on official company letterhead. Please remember that photocopies of this form will *NOT* be accepted. Forms with white-out will *NOT* be accepted.
3. Please submit a copy of the Certificate of Completion attached to this form. Information documented on this form should match information on Certificate of Completion.

TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____

CONTACT NUMBER: _____

CONTACT EMAIL:_____

AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a State Approved Nurse Aide Training and Competency Evaluation Program (NATCEP) on _____.
The number of classroom hours completed was _____.

The number of clinical hours completed was _____.

Print Name: _____Signature: _____

Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____

County, In the State of _____.

Print Name: _____ (Place Notary Seal Here)

Signature: _____

*Please attach copy of Certificate of Completion to this form