



FOR OFFICE USE ONLY

Receipt #

ID #

Issue Date

License #

**Rhode Island
Nursing Assistant Advisory Board**

Room 105
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

**License As A
Nursing Assistant**

By Reinstatement

OFFICE USE ONLY

[Empty box for applicant name]

Applicant - Print Name (First/MI/Last)

Phone: (401) 222-5888

TTY/TDD: (800) 745-5555

Fax: (401) 222-3352

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

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Licensure Requirements

Both Endorsement and Reinstatement Applicants

- Recent passport type photograph.
- Applicants **MUST** provide a Full BCI Check from **the Attorney General's Office only** (Attorney General's Office, 150 South Main Street, Providence, RI 02903 - (401) 274-4400).
- Photocopy of active license/registration from current state.
- Processing Fee: \$35.00 (covers application processing and initial license).
- Proof of completion of Training Program of 100 or more hours **OR** Proof of completion of Training Program of less than 100 hours (**documentation must state number of hours completed**) **AND** proof of employment for 3 months full time in Nursing Home, Hospital or Home Care Agency (See Employment Verification form, page 11). (**Reinstatement only**)
- Proof of employment for at least one 8-hour shift within the past two years (license must be current at the time of employment) in Nursing Home, Hospital or Home Care Agency (See Employment Verification form, page 11). (**Reinstatement only**)
- Verification from all state(s) of licensure either current/expired/lapsed (see Interstate Verification form, page 10). (**Endorsement only**)

Rules and Regulations/Laws

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

Chapter 23, Title 17.9 entitled "Registration of Nursing Assistants" can be downloaded at the following web site:

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

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 Professionals Regulation, and the Rhode Island Nursing Assistant Advisory Board (Board).

Application Process

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have a malpractice, criminal or disciplinary history in Rhode Island, or another state, it can take an additional 2 or 3 months for processing your application.

Licenses will be issued within 7-10 working days following approval of the license and will expire every two years. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

<http://www.health.ri.gov/forms/changeofaddress/professions.pdf>

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

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

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5888.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may 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. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the reinstatement fee of **\$35.00** payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is **NONREFUNDABLE**.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 9). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

**Rhode Island Department of Health
Nursing Assistant Advisory Board
Room 105, 3 Capitol Hill
Providence, RI 02908-5097**



State of Rhode Island Nursing Assistant Advisory Board

Application for License as a Nursing Assistant by Reinstatement

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. 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 Division of Taxation to verify that no taxes are owed to the State."

3. Gender

Male Female

4. Date of Birth

____ / ____ / 19____
 Month Day Year

5. Home Address

It is your responsibility to notify the board 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 (Format for email address is Username@domain e.g. applicant@isp.com)

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

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

 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

8. Training Information

Name of School/Training Program

Name of School/Training Program

Address (Number and Street)

Address (Number and Street)

City State Zip Code

City

State

Zip Code

License Number of School/Training Program

License Number of School/Training Program:

Date Class Began: Date Graduated:

Date Class Began:

Month

Day

Year

Date Graduated:

Month

Day

Year

Test Site:

Employment Date: Test Date:

Employment Date: (If Applicable)

Month

Day

Year

Test Date:

Month

Day

Year

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

9. Original (and Other) State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state?

Yes No

If the answer to this question is "yes", list the license number(s) of the original state (and any other states) of licensure below:

Original Licensure

State License Number

State

License Number

Other State Licensure

State License Number

State

License Number

Other State Licensure

State License Number

State

License Number

Other State Licensure

State License Number

State

License Number

10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8 1/2 x 11 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?

Yes No

Abbreviation of State and Conviction¹ (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" to any question, 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, on a separate sheet of paper. If you answer "Yes" to any question you **must** attach originals, or certified copies of any court documentation to this application.

12. Affidavit of Applicant

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

Make sure that you and the notary public have completed all components accurately and completely.

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 the Rhode Island Nursing Assistant Advisory Board 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 instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not 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 in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- I have read and understand the "Instructions for Completing the Application".
- I have completed the application as instructed (pages 5-8).
- I have attached the cover page of the application.
- I have completed Section 12, "**Affidavit of Applicant**", and have had the form notarized by a notary public.
- I have attached a photograph to Section 13, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have a **check or money order** (preferred), made payable (in U.S. funds only) to the "**RI General Treasurer**" in the amount of **\$35.00** and attached it to the upper left-hand corner of the first (Top) page of the application (All fees are NON-REFUNDABLE).
- I have arranged my Board Application materials in the following order.
 1. Fee (attached as instructed).
 2. Board Application (including cover page) (pages 5-8).
 3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application **MUST** indicate the section for which the information is being reported.]
- I have mailed the above application materials directly to the Rhode Island Nursing Assistant Advisory Board.
- I have mailed the "Interstate Verification form(s)" to all states where I have been licensed.**
- I have mailed "Verification of Employment" form to verify my full-time employment of at least one 8 -hour shift within the past two years in a nursing home, hospital, or home care agency.
- I have enclosed a photocopy of a current NA license from the state of _____.
- I have requested a full Bureau of Criminal Investigation (BCI) check as instructed.



Substitute forms are not acceptable, One (1) form is required for each state in which you hold, or have held a license. Copy this form as needed.

Rhode Island Nursing Assistant Advisory Board

Room 105, 3 Capitol Hill
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 Nursing Assistant Advisory Board requires that the following 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 Nursing Assistant Advisory Board at the above address.

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

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

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 #5 through #8, please explain on a separate sheet of paper and attach it to this form.

Licensed by Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not by examination, how was license obtained? Endorsement _____ (State) Other _____ (Explain)		
Applicant has completed and passed the National Certification Exam: <input type="checkbox"/> Yes <input type="checkbox"/> No Score _____ Level of Exam: _____	License Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued: _____	Expiration Date: _____

Questions:

1. Has this applicant met all relevant state and federal requirements under OBRA '87 and '89 for Nurse Aide 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

If you answer "yes" to any of the questions #5 through #8, please explain on a separate sheet of paper and attach it to this form.

Certification:

Signature	Date
Type or Print Name	
Title	
Full Name of Licensing Board	

Please Affix Board Seal Here

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



Rhode Island Nursing Assistant Advisory Board

Room 105, 3 Capitol Hill
 Providence, RI 02908-5097
 (401) 222-5888

NURSING ASSISTANT VERIFICATION OF EMPLOYMENT FORM

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

Print/Type Full Name _____

Signature _____

Date _____

Previous Names Used _____

Social Security Number _____

Date of Birth _____

License Number _____ Date Issued _____

IMPORTANT!: APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO EMPLOYER

THIS SECTION TO BE COMPLETED BY THE EMPLOYER/EMPLOYING AGENCY

The individual named above has made application to the Rhode Island Department of Health, Nursing Assistant Advisory Board to become reinstated as a Nursing Assistant. Rhode Island Rules and Regulations for the licensure of Nursing Assistants requires any individual has worked in another state as a Nursing Assistant to obtain verification of Employment for a period of at least one 8-hour shift. This form is provided for that purpose.

This is to certify that _____ has completed a minimum of one 8-hour shift of employment in a skilled nursing facility.

Name of Skilled Nursing Facility: _____

Located at (street 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 knowledge

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