FOR OFFICE USE ONLY

Nursing Assistant Checklist

- ☐ Application
- ☐ Application Fee
- ☐ Valid ID
- ☐ BCI
- ☐ Out of State License Verification
- ☐ Out of State Training Program or 3 Months Full Time Employment

FOR OFFICE USE ONLY

☐ PW ________	☐ PP ________
☐ FW ________	☐ FP ________
☐ FW ________	☐ FP ________
☐ FW ________	☐ FP ________

Receipt #

ID #

Issue Date

License #

Name: ____________

License Number: ____________

Rhode Island Department of Health

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For
License As A Nursing Assistant

☐ 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

Have you EVER held a license as a Nursing Assistant in Rhode Island? ☐ Yes ☐ No
If Yes, please provide your RI License Number NA____________________

Applicant - Print LEGAL Name - NAME MUST MATCH STATE ID

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**

LICENSURE REQUIREMENTS

Please review the following checklists CAREFULLY. Listed are all of the documents and fee that you will need for the application. All items must be submitted before an application is complete. Applications are valid for a 1 year period. **You are responsible for notifying RIDOH, in writing, within ten (10) days, if your home address changes.**

All Applicants - Must Provide the following

- ☐ Completed Application with Cover Page; and
- ☐ 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 to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE; and
- ☐ Copy of Driver's License or State Issued ID
- ☐ **Original** BCI (Background Check) with stamp and seal from the RI Attorney General's Office **only**, For information on this process please visit their website at: http://www.riag.ri.gov/BCI. If positive BCI, a detailed explanation is required for each incident. BCI must be dated within 4 months of the date of this application.
- ☐ 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.
- ☐ Evidence of a current license as a Nursing Assistant in another state **Completed Interstate Verification Form enclosed in this application**. You must complete the top section of the form and send the form to the other state board; and

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AND: Choose ONE below on how you are applying for a license. Include all of the required information to complete your Nursing Assistant application.

- ☐ **Evidence of 100 Nursing Assistant Training Program Hours** - Copy of your Nursing Assistant Training Program Certificate of Completion or a letter from your school on company letterhead. **Evidence MUST** state the number of hours **AND** must include a **minimum of 20 hours of practical clinical training under supervision**.

OR

- ☐ **Evidence of 3 Months Employment as a Nursing Assistant** - 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 enclosed in this application.** You must complete the top section of the form and send the form to your employer. This verification must include one (1) hour per month of in-service training for each month you have been employed.

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 1 9

5. Home Address

It is your responsibility to notify RIDOH of all address changes **within ten (10) days.**

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.

8. 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		***Other State Licensure***	
State	License Number	State	License Number

Other State Licensure		***Other State Licensure***	
State	License Number	State	License Number

9. 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 not 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

If you answer yes, you must give complete details as to what led to the arrest(s).

10. 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.

11. Affidavit of Applicant

Complete this section and sign.

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) ______________________

Important Licensure Information

Allow a minimum of 8 weeks for the entire licensure process to be completed. Once compete you will be contacted in writing and you may NOT practice as a Nursing Assistant in Rhode Island until you have received your license.

If you are applying by Examination and are currently in a Nursing Assistant Training Program you will be given a 120 day temporary permit. No extensions will be granted.

Notify RIDOH within 10 Days of a change of address.

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. RIDOH will not, for any reason, accelerate the processing of one applicant at the expense of others.

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3 Capitol Hill, Room 104
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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 return directly to the above address. Thank you for your prompt cooperation.

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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 within the last year as a Nursing Assistant. This also verifies that (1) hour of In-Service Training per month of employment has been completed.

Name of Employer/Employing Agency: ______________________________

Address:: ______________________________

City, State, Zip Code: ______________________________

Phone Number: ______________________________

Dates of Employment: From ______________ (month/day/year) To ______________ (month/day/year)

Additional Comments:

____

____

Certification:

Signature of Administrator/DNS ____________ Date ____________

Type or Print Name ____________ Title ____________

Phone Number ____________

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.