CERTIFIED NURSE AIDE REGISTRATION AND MEDICATION I OR II RENEWAL APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59966 (R2-2012)

Online renewal is available and encouraged for all types of nurse aides and medication assistants. Please use the following web address**: http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm**

Please check the appropriate Medication Assistant box to the right	☒ Certified Nurse Aide (No Fee) ☐ Medication Assistant I (Non-Refundable Fee $25.00) ☐ Medication Assistant II (Non-Refundable Fee $25.00)

REGISTRANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name		Maiden/Middle Initial	M ☐	F ☐
Current Mailing Address (Include C/O Address)			County		
City	State	Zip Code	Social Security Number (Required)		
Date of Birth	E-Mail Address				
Home Phone	Work Phone		Cell Phone		
Registrant ID #			Current Expiration Date		

ALL QUESTIONS MUST BE COMPLETED BY REGISTRANT

1.	Have you ever been arrested, charged, or convicted of a felony (*You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action)* within the last two years?	☐ Yes	☐ No	
2.	Since you last renewed, or if this is your first renewal, has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	Since you last renewed, or if this is your first renewal, have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No	
4.	Since you last renewed, or if this is your first renewal, have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	Since you last renewed, or if this is your first renewal, have you been denied registration or licensure by any other jurisdiction?	☐ Yes	☐ No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	☐ Yes	☐ No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	☐ Yes	☐ No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	☐ Yes	☐ No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. **Have you attached the appropriate documents?**	☐ Yes	☐ No	☐ NA

APPLICATION CERTIFICATION

I certify the information provided is true, correct and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.	
Applicant Signature	Date

FOR STATE USE ONLY

Date Received: _____ **Amount Received: $**_____ **Cash MO or CK#**_____

THE BOX BELOW MUST BE COMPLETED BY A NORTH DAKOTA EMPLOYER ONLY

The registrant below has *competently* performed a minimum of eight (8) hours of nursing or nursing related services for pay for the employer specified below.

Last date /shift worked in North Dakota during certification period
(Cannot be later than the expiration date)

(THE NEW EXPIRATION DATE WILL BE EXTENDED 2 YEARS FROM LAST DATE WORKED)

Employer Type: ☐ Long Term Care Facility
☐ Hospital
☐ Other (Specify)_____

Last Date Worked

Month	Day	Year

Name of Facility/Employer		**City**
Supervisor's Signature	**Date**	**Phone Number**
My signature above indicates the information is true and correct to the best of my knowledge.		**Employer E-mail**

Medication Assistant Competency Verification

This Certified Nurse Aide has been validated to meet the competency requirements as a Medication Assistant consistent with NDAC 33-43-01-14 or 33-43-01-15 during the past year as indicated by my signature below.

Signature	Date
Licensed Nurse or Registered Nurse Number	Expiration Date

Medication Assistant Employment Verification

Employer	Phone Number	
E-mail Address		
Signature	License Number	Date

Make checks and/or money orders payable to the North Dakota Department of Health.

All completed forms and checks or money orders must be sent or delivered together to:

North Dakota Department of Health
Division of Accounting
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov