INITIAL HOME HEALTH AIDE APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59960 (R2-2012)

APPLICANTS, 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	
Name of Employer			City	State
Employer's Contact Name		Employer's Phone Number		
Registrant ID #		Current Expiration Date		

ALL QUESTIONS MUST BE COMPLETED BY APPLICANT

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.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	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.	Have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	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#_________

Home Health Aide Training Program (when applicable)

If you are not currently enrolled in or have not completed a Home Health Aide training program, **skip to the next section**.

Name of Home Health Aide Training Program				
Address		City	State	Zip Code
Date of Enrollment		Date of Completion		
Total Hours of Training Program	Licensed/Registered Nurse Number		Expiration Date	
Signature			Date	

Home Health Aide Nurse Competency Verification

Licensed or registered nurse verification of Home Health Aide applicant's competency (within the last year) to provide Home Health Aide services.

This Home Health Aide has completed the necessary competency verification within the past year, as indicated by NDAC 33-43-01-05. I certify the competency of the Home Health Aide applicant by signature below:	
Signature	Date
Licensed/Registered Nurse Number	Expiration Date

APPLICANT EMPLOYMENT INFORMATION

Employment Status ☐ Employed ☐ Not Employed	Date of Hire as a Home Health Aide

AGENCY (EMPLOYER) INFORMATION AND SIGNATURE

Agency (If applicable)			Phone Number
Address	City	State	Zip Code
Employer Signature		Date	

Please remit $25 (U.S. dollars) Non-refundable Fee

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 by e-mail at naregistry@nd.gov