



HOME HEALTH AIDE RENEWAL APPLICATION

North Dakota Department of Health
 Division of Health Facilities
 SFN 59963 (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

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

ALL QUESTIONS MUST BE COMPLETED BY REGISTRANT

1.	Have you ever been arrested, charged, or convicted of a felony (<i>You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action</i>) within the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Since you last renewed, or if this is your first renewal, have you been denied registration or licensure by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> NA

REGISTRATION 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.

Signature	Date
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For State Use Only

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

Home Health Agency (Employer) to complete this page.

Home Health Aide Nurse Competency Verification

A licensed or registered nurse must verify the Home Health Aide's (applicant) 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 or Registered Nurse Number	My license expires on (Date)

APPLICANT EMPLOYMENT INFORMATION

Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Not Employed	Date of Hire as a Home Health Aide
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AGENCY (EMPLOYER) INFORMATION AND SIGNATURE

Agency (If applicable)		Phone Number	
Address	City	State	Zip Code
Employer or Licensed Nurse 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 us by e-mail at naregistry@nd.gov