INITIAL NURSE AIDE APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59961 (R3-2016)

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 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 required 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 FOLLOWING IS TO BE COMPLETED BY A LICENSED NURSE OR EMPLOYER

VERIFICATION OF COMPETENCE

For each area, the licensed nurse or employer verifies that the nurse aide has demonstrated competencies in the following areas. **Signature of Employer** _____ **Date** _____ **OR** **Signature of Licensed Nurse** _____ **Date** _____ **AND** **License Number** _____	Date of satisfactory competency verification **(within the last 4 months)** **MM/DD/YYYY**	Comments
1. Infection control.		
2. Safety and emergency procedures.		
3. Collection and documentation of basic objective and subjective client data.		
4. Activities of daily living (applicable to setting).		
5. Decision-making skills.		
6. Client rights.		
7. Communication and interpersonal skills.		
8. Client cognitive abilities and age specific needs.		

APPLICANT EMPLOYMENT INFORMATION

Employment Status ☐ Employed ☐ Not-Employed	Date of Hire as a Nursing Aide **(MM/DD/YYYY)**

EMPLOYER INFORMATION AND SIGNATURE

Employer (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