



INITIAL NURSE AIDE APPLICATION

North Dakota Department of Health
 Division of Health Facilities
 SFN 59961 (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 (<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.	Has your registration been sanctioned or disciplined by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3.	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.	Have you been investigated or are you presently being investigated by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5.	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 required documents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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
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FOR STATE USE ONLY	Date Received: _____	Amount Received: \$ _____	Cash MO or CK# _____
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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.	Date of satisfactory competency verification (within the last year)	Comments
Signature of Employer _____ Date _____ OR Signature of Licensed Nurse _____ Date _____ AND License Number _____	MM/DD/YYYY	
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 <input type="checkbox"/> Employed <input type="checkbox"/> Not-Employed	Date of Hire as a Nursing Aide (MM/DD/YYYY)
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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