



**CERTIFIED NURSE AIDE REGISTRY ENDORSEMENT**  
 NORTH DAKOTA DEPARTMENT OF HEALTH  
 DIVISION OF HEALTH FACILITIES  
 701.328.2353  
 SFN 50645 (R14-2017)



**Please Print Legibly**

**List all states you are/were certified, current/expired**

Social Security Number		Certified in the following states:				Last Date Worked (Indicate for each State)			
		1. _____	5. _____	1. _____	5. _____				
		2. _____	6. _____	2. _____	6. _____				
		3. _____	7. _____	3. _____	7. _____				
		4. _____	8. _____	4. _____	8. _____				
Nurse Aide Registrant ID Number for each State									
1)		2)		3)		4)			
5)		6)		7)		8)			
First Name			Last Name			Maiden/Middle		M / F	
Date of Birth		Current Mailing Address				Apartment/Unit #			
City		State	Zip Code	County		Daytime Phone			
E-Mail Address						ND CNA # if Applicable			
Nurse Aide Program Completed: Facility Name, and City					Date Completed		Today's Date		
If Competency Tested only, complete this box: Site Name, and City					Date Tested				

**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> )?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	Has your registration or nursing license 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 the appropriate documents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

**Please  
Choose  
One**

1. e-mail this form to [naregistry@nd.gov](mailto:naregistry@nd.gov), or
2. fax to 701.328.1890, or
3. mail to: CNA Registry 600 E. Boulevard Ave., Dept. 301 Bismarck, N.D., 58505-0200