DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

Delaware Nurse Aide Registry
Reciprocity (Out of State CNAs to Delaware)
General Information

Part I: Eligibility

A nurse aide from another state may apply for certification on the Delaware Nurse Aide Registry instead of completing a Delaware state-approved Nurse Aide Training and/or Competency Examination by meeting the following qualifications. The individual:

1. Is currently listed on another state's Nurse Aide Registry with active status. (You must be a GNA if from state of MD.)
2. Has no pending or substantiated findings of patient abuse, neglect, or misappropriation of resident/patient property recorded on another state's Nurse Aide Registry.
3. Has either been employed as a Certified Nurse Aide for the equivalent of at least 3 months full time (420 hours), for pay, under the supervision of a registered nurse or physician **OR** has completed a CNA training course of at least 150 hours.

Part I1: Instructions

1. **Section A** of this application on page 2, *Application for Reciprocity*, must be completed clearly by the applicant/CNA. Please sign the bottom verifying that the information provided is accurate and attach the three items listed below.

2. First, you must attach a personal check made payable to the "State of Delaware" in the amount of $30. This is non-refundable.

3. Second, you need to attach a legible photocopy of a picture ID that shows your birth date and the correct spelling of your name.

4. Third, please attach a copy of your current state certification card or verification printout from your state's website. The Delaware Nurse Aide Registry will verify registry status in the state(s) that currently list your name as a current Certified Nurse Aide.

5. Finally, please complete the name and phone number on top of page 3, Section B before mailing to a past employer or training school administrator.

6. **Section B** of this application on page 3, is *to be completed by a past employer* and requires verification of employment as a nurse aide in a health setting where you worked as a Certified Nurse Aide under the supervision of a registered nurse or physician performing nursing related services for pay **OR** verification from your *CNA training school administrator* if you completed a minimum of 150 training hours. This past employer or training school administrator can mail this form directly back to the Delaware CNA Registry.

7. You must meet all eligibility requirements in Part I and the Division must receive a thoroughly completed Section A with all required attachments and Section B in order to be approved for placement on the Delaware Nurse Aide Registry.

8. Please note, we no longer issue certification cards in the state of Delaware and you will not be notified of certification by mail. If you would like to be notified of your Delaware certification please include your email address in Section A on page 2. You may also call (302) 424-8600 to confirm your certification or search our website for your name by going to the following website: http://www.prometric.com/nurseaide/DE -then click on the link to the Delaware Nurse Aide Registry.

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Delaware Nurse Aide Registry
Application For Reciprocity

SECTION A: To be completed by NURSE AIDE (must be GNA if from the State of MD)

Instructions:

PRINT OR TYPE THE REQUIRED INFORMATION BELOW AND ATTACH THE FOLLOWING:
(Note: Photocopies of this completed application are not acceptable – your original signature is required.)

1. A PERSONAL CHECK MADE PAYABLE TO "STATE OF DELAWARE" IN THE AMOUNT OF $30. THIS IS NOT REFUNDABLE.
2. A LEGIBLE PHOTOCOPY OF A PICTURE ID THAT SHOWS BIRTH DATE AND THE CORRECT SPELLIING OF YOUR NAME. .
3. A COPY OF YOUR CURRENT OUT OF STATE CERTIFICATION CARD OR VERIFICATION FROM YOUR STATE'S WEBSITE.

MAIL TO:

Delaware Nurse Aide Registry
3 Mill Road, Suite 308
Wilmington, DE 19806
(302) 421-7403

Please Print or Type

NAME: _____/_____/_____
(Last) (First) (Middle)

CURRENT CNA CERTIFICATION NUMBER: _____

Date of Birth _____/_____/_____ Gender: Male____ Female____

Email Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

1) Are you currently certified as a nurse aide? Yes No
What state(s)? _____

2) Have you ever had a negative finding entered against you on any state registry? Yes No

3) Have you ever been convicted of a criminal offense including any guilty pleas and no contest pleas? Yes No
If yes, give details on separate paper.

4) I have performed the equivalent of at least three months of full time (420 hours) nursing or nursing related services for pay under the supervision of a licensed nurse or physician. Yes No

5) Have you completed a training and competency evaluation program of at least 150 hours? Yes No

6) Please list all states in which you have been certified: _____

I certify that all of the information provided above is true and complete. I give my permission to any employer and any state registry to disclose all information requested on this application.

_____ _____
Signature – Nurse Aide Date

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Applicant Name: _____
Phone Number: _____

SECTION B: To be completed by Employer (showing the equivalent of at least 3 months of full time experience) or Training School (only if training hours were at least 150 hours)

Instructions:

(Photocopies of this completed application are not acceptable – your original signature is required)

1. Forward this page of application to your employer **or** training school (if program was at least 150 hours) to complete Section B.
2. Employer or training school must notarize signature at the bottom of this section and mail to:

Delaware Nurse Aide Registry
3 Mill Road, Suite 308
Wilmington, DE 19806
(302) 421-7403

EMPLOYER or TRAINING SCHOOL NAME: _____

MAILING ADDRESS: _____PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Complete either number 1 or number 2 below:

(1) As the **employer**, I certify that the individual named above is/was employed by me as a **Certified Nurse Aide** and performed nursing/nursing related duties from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____, **under the supervision of a licensed nurse or physician** for _____**total hours**. I am not aware of any disqualifying misconduct.

OR

(2) As the **training school administrator**, I certify that the individual named above completed a training and competency evaluation program of _____ **hours**.

_____ _____ _____
Signature – Employer/Training Administrator Print Name Date

Sworn and subscribed to me on this _____ day of _____, 20_____, in _____ County, in the State of _____

Place Notary Seal Here _____ _____
Signature-Notary Public Date Commission Expires

_____
Print Name