PART I: ELIGIBILITY - A nurse aide from another State may apply for certification to the Delaware Nurse Aide Registry in lieu of completing a State Approved Nurse Aide Training and Competency Evaluation Program by meeting the following qualifications:

1. Be listed on another State’s Nurse Aide Registry as CURRENT or ACTIVE, and in good standing. You must have a Geriatric Nurse Aide (GNA) certification if coming from the State of Maryland.
2. Have no pending or substantiated findings of adult/child abuse, neglect, financial exploitation, and/or misappropriation of resident/patient property recorded on any State’s Nurse Aide Registry.
3. Have work experience as a Certified Nurse Aide (CNA) [within the last 24-months] for at least three (3) months (full time) or at least 420 hours under the direct supervision of a Registered Nurse (RN) or Physician performing nursing related duties for pay. Nursing related duties include but are not limited to the following: bathing, dressing, grooming, toileting, ambulating, transferring, and feeding, observing and reporting the general well-being of the person(s) to whom a qualified person is providing care.
4. Have completed Nurse Aide Training at an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) with the number of hours at least equal to that required by the State of Delaware (150 total hours).

PART II: INSTRUCTIONS - The following is a detailed checklist of required items:

☐ 1. Application for Reciprocity (Page 3/4): Must be completed by the applicant/CNA. PLEASE PRINT LEGIBLY. Please sign and date the bottom of the page verifying that the information provided is accurate. Please answer ALL questions. **Incomplete forms will be returned. Forms with white out will not be accepted.**

☐ 2. Employer Verification Form (Page 5): To be completed by a current or former employer (within the last 24 months). Verification of employment should include dates of employment, status (FT, PT, or Per Diem), job title, and the total number of hours worked during your tenure. Financial/Salary information is not required for this verification. Completed forms must be notarized. W-2’s will not be accepted for employment verification. The Division reserves the right to randomly contact the Employer to verify the validity of submitted documentation. **Forms with white out will not be accepted.**

☐ 3. Training Program Verification Form (Page 6): To be completed by the Training Program Administrator. This verification form should be submitted if the applicant does not have work experience equal to 3-months (full time) or 420-hours. Training must have been completed in a Nurse Aide Training and Competency Evaluation Program (NATCEP) with a total number of hours equal to or greater than that required by the State of Delaware. The requirement for Delaware is 150 total hours (75-hours classroom/theory, 75-hours clinical) in a certified/skilled long-term care facility. The Division reserves the right to randomly contact the Training Program Administrator to verify the validity of submitted documents. **Forms with white out will not be accepted.**

☐ 4. Provide verification of current/active State Certification in good standing. Please list ALL States in which you have ever been certified whether currently active or inactive. You do not need to send verification from any State other than the State from which you are transferring.
5. A legible copy of a Government issued Photo ID which shows your full [legal] name and your date of birth (preferably a State Driver License/Identification or a Passport). You do not need to send a copy of your social security card.

6. THE SEALED/UNOPENED COPY of the National Practitioner Data Base self query. Please visit [https://www.npdb.hrsa.gov/](https://www.npdb.hrsa.gov/) to request a search of your information; the cost is $4.00 for this self query. You will be required to submit payment using a credit/debit card. Once your request has been submitted, you will receive both an online response via email, and a sealed copy via US Mail. *DO NOT OPEN THE ENVELOPE WHEN YOU RECEIVE IT* This sealed/unopened copy should be submitted along with your application and other supporting documents. **Applications will be returned if there is evidence of tampering or evidence that the envelope has been opened.**

7. The Reciprocity Processing fee is $30; please submit payment along with all other documents. Payment should be in the form of a check or money order, and made payable to: STATE OF DELAWARE. Please note that all fees made payable to the State of Delaware are non-refundable if your application is denied for any reason.

Mail Completed Application (Pages 3-6) Along With All Supporting Documentation and Payment To:

DHSS, Division of Health Care Quality
Office of Long Term Care Residents Protection
Attn: CNA Registry/Reciprocity
24 NW Front Street, Suite 100
Milford, Delaware 19963

If you have any questions, please call 302-424-8600 or 302-421-7410
Delaware Health and Social Services
Division of Health Care Quality, Office of Long Term Care Residents Protection
DELAWARE NURSE AIDE APPLICATION FOR RECIPROCITY

APPLICATION: TO BE COMPLETED BY NURSE AIDE

Instructions: Type or print (legibly). Your original signature is required; photocopies of this form will not be accepted. Forms with white out will not be accepted.

LAST NAME: ________________ FIRST NAME: ________________ MIDDLE NAME: ________________
Applicant’s name should match name as it appears on the CNA Registry in your State. If different from Photo ID please provide documentation.

MAILING ADDRESS: ____________________________ CITY: ____________________________

STATE: _______  ZIP CODE: ________  DAY TIME PHONE #: ____________

EVENING PHONE #: ____________ EMAIL ADDRESS: ______________________________________

DATE OF BIRTH: ____/____/_____  GENDER: Male ____ Female ____  LAST 4 DIGITS OF SSN: ______

HAVE YOU EVER BEEN CERTIFIED IN THE STATE OF DELAWARE? YES ____  NO ____
If YES, please provide Certification #: ____________________ (*Note: If your Delaware Certification lapsed within the past 24-months you may not be eligible for Reciprocity. Please contact our office.)

CURRENT STATE OF CERTIFICATION: ____  CERTIFICATION NUMBER: ____________________
(Must be GNA if from the State of Maryland) Please attach proof of current/active certification

Please list below ALL states in which you have EVER been certified whether currently active or inactive: ______  ______  ______  ______  ______  ______  ______  ______  ______

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect, financial exploitation and/or misappropriation of resident/patient property)? Yes ____ No ____
If NO, you may not be eligible for reciprocity. Please contact our office

2) Have you EVER had a negative finding entered against you on ANY State registry? Yes ____ No ____
If YES, give details on a separate sheet of paper.

3) Have you EVER been convicted of a criminal offense including any guilty pleas and/or no contest pleas? Yes ____ No ____
If YES, give details on a separate sheet of paper

4) Have you worked in a healthcare setting within the last 24 months as a CNA for at least three months or at least 420 hours [for pay] under the supervision of a Registered Nurse or Physician? Yes ____ No ____
If you answered YES to this question, please have Page 5 completed by your employer, and attach to this form. If you answered NO to this question, please answer question #5

REVISED 10-29-2021
*If you answered YES to question #4 above, please check this box and skip question #5

5) If you have NOT worked for pay for at least three months full time and/or don’t have at least 420 hours, have you completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) of at least 150 hours? (75 hours classroom/theory, 75 hours clinical) Yes No

If you answered YES to this question, please have Page 6 completed by your Training Program Administrator, and attach to this form. If you answered NO to this question, you may not be eligible for reciprocity. Please contact our office.

*I certify that all information provided in this application is true. I understand that my application may be denied for submitting false and/or fraudulent information. If approved, I understand that my Certification is subject to disciplinary action if findings later determine that I committed fraud, misrepresentation, and/or deceit in order to obtain the certification.

Signature of Applicant: ____________________________ Date: ______________
Applicant’s Name (As listed on Page 3): ____________________________________DOB: ___________

1. This form is to be completed by the Employer. Applicants, please enter (only) your name and date of birth above).

2. Forms must be notarized. If there is no licensed notary in the facility, Employers may submit verification on official company letterhead. Please remember that photocopies of this form will NOT be accepted. Forms with white-out will NOT be accepted.

3. Please Note: W-2s will NOT be accepted as proof of employment. Calls will not be made to Work Net or The Work Number.

EMPLOYER NAME: ________________________________________________

MAILING ADDRESS: ________________________________________________

CITY: ____________ STATE: ______ ZIP CODE: _______ CONTACT NUMBER: _______________

Please complete either Section 1 or Section 2 below:

Section 1
AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked FULL TIME from (mm/dd/yyyy)____________________ to (mm/dd/yyyy)________________ for pay, under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: ______________________ Signature: _____________________
Title: ________________________ Date: _____________________

Sworn and subscribed to me on this _____day of ______________, 20____, in ______________ County, In the State of ____.
Print Name: __________________________ (Place Notary Seal Here)
Signature: __________________________

OR...

Section 2
AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked from (mm/dd/yyyy)____________________ to (mm/dd/yyyy)________________ for pay, for a total of ________ hours under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: ______________________ Signature: _____________________
Title: ________________________ Date: _____________________

Sworn and subscribed to me on this _____day of ______________, 20____, in ______________ County, In the State of ____.
Print Name: __________________________ (Place Notary Seal Here)
Signature: __________________________
Delaware Health and Social Services
Division of Health Care Quality, Office of Long Term Care Residents Protection
DELAWARE NURSE AIDE APPLICATION FOR RECIPROCITY

TRAINING PROGRAM ADMINISTRATOR VERIFICATION FORM

Applicant’s Name (As listed on Page 3): ________________________________ DOB: __________

1. This form is to be completed by the NATCEP Administrator. Applicants please enter (only) your name and date of birth above.

2. Forms must be notarized. If there is no licensed notary in the facility, Program Administrators may submit verification on official company letterhead. Please remember that photocopies of this form will NOT be accepted. Forms with white-out will NOT be accepted.

3. Please submit a copy of the Certificate of Completion attached to this form. Information documented on this form should match information on Certificate of Completion.

TRAINING PROGRAM NAME: ________________________________________________

MAILING ADDRESS: _________________________________________________________

CITY: ____________STATE: ______ZIP CODE: _________CONTACT NUMBER: _______________

AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a State Approved Nurse Aide Training and Competency Evaluation Program (NATCEP) on _________________. The Program was a total of ________ hours.

_______ Hours class/theory
_______ Hours clinical [in a certified/skilled long-term care facility]

Print Name: ___________________ Signature: _____________________________

Title: ___________________ Date: _________________

Sworn and subscribed to me on this _____day of _____________, 20__, in _____________ County, In the State of _______.

Print Name: __________________________ (Place Notary Seal Here)
Signature: _____________________________

*Please attach copy of Certificate of Completion to this form