DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

Delaware Nurse Aide Application for Reciprocity

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:

1. Currently listed on another State's Nurse Aide Registry in good standing.
   (You must have a GNA in current/active status if from the State of Maryland)
2. Have no pending or substantiated findings of adult/child abuse, neglect, or misappropriation of resident/patient property recorded on another State's Nurse Aide Registry.
3. Have either been employed as a Certified Nurse Aide for the equivalent of **at least 3 months full time (at least 420 hours)**, for pay, under the supervision of a Registered Nurse or Physician **OR** Have completed a CNA Training Program of **at least 150 hours.**

PART II: Instructions

The following is a checklist of required items:

☐ 1. **Section A - Page 2** *Application for Reciprocity* must be completed by the applicant/CNA. **PLEASE PRINT LEGIBLY**. Please sign the bottom of the page verifying that the information provided is accurate.

☐ 2. Section B – Page 3 Employer/Training Program Attestation Form to be completed by a current or previous employer and requires verification of employment. You must have worked in a health care setting as a CNA under the supervision of a Registered Nurse or Physician; **OR** verification from your CNA Training Program Administrator verifying at least **150 training hours**.

☐ 3. Provide verification of certification from the State in which you are currently certified. The Division will verify the status of your certification to assure there are no negative findings.

☐ 4. A photocopy of a Picture ID that shows your full (legal) name and your date of birth (i.e. Driver's License or State ID)

☐ **5.** Processing fee of $30 - Payment should be made in the form of a **check or money order made payable to: STATE OF DELAWARE.** This fee is non-refundable.

MAIL COMPLETE APPLICATION TO:

Aleen Wilker, RN, CRNA, APN ~ CNA Compliance Nurse
Division of Health Care Quality
3 Mill Road, Suite 308
Wilmington, DE 19806-21643

Original Employer/Training Program Attestation Forms must accompany application; we will no longer accept faxed copies. Applications received without page 3 will be returned to the applicant. Approved applicants will be placed on the Delaware Nurse Aide Registry for a period of two years (24-months); you will be notified via email once your application has been approved. If you do not provide an email address on page 2 of your application, you may not receive notification of your certification approval. Please allow up to 30-days for the processing of your application. If you do not receive notification after 30-days you may call (302) 421-7419 to check on the status of your application or search http://www.prometric.com/nurseaide/DE

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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

Instructions: Type or print (legibly). Your original signature is required; photocopies will **not** be accepted.

NAME: _____ _____ _____
(Last Name) **(First Name)** **(Middle Name)**

CURRENT CNA CERTIFICATION NUMBER: _____ **STATE:** _____

DATE OF BIRTH: _____/_____/_____ **GENDER:** **Male** _____ **Female** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **EMAIL ADDRESS:** _____

Please circle the appropriate answer:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect ,or misappropriation of resident/patient property)? Yes No
If NO, give details on a separate sheet

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

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 a separate sheet

4) Have you worked in a facility as a CNA for at least three months full time or at least 420 hours for pay under the supervision of a Registered Nurse or Physician? Yes No
If YES, please have page 3 notarized and attach to this application

5) If you have not worked for three months full time and/or don't have at least 420 hours, have you completed a CNA Training and Competency Evaluation Program of at least 150 hours? Yes No N/A

If you answered YES to question #4 above, please circle N/A. If you answer YES to this question, please have page 3 notarized and attach to this application.

6) Please list **ALL** states in which you have **EVER** been certified (whether currently active or inactive):

_____

***I certify that all information provided above is true and complete. I understand that my application will be denied for submitting false and/or incomplete information and my application fee will be forfeited.**

_____ _____
Signature **Dat**

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

Employer/Training Program Attestation Form

Applicant Name: _____
Phone Number: _____

SECTION B: To be completed by Employer or Training Program Administrator

NOTE: Photocopies of this form are not acceptable; original signature and notary seal are required.

1) This form should be mailed and/or hand delivered to your Employer/Training Program Administrator. Once completed, this form should be returned to applicant and submitted with completed application.
2) Employers/Training Schools who do not have a notary available may submit verification on company letterhead. Complete statement 1) or 2) below on official letterhead and submit in lieu of notarized document.

EMPLOYER or TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE NUMBER: _____

Complete either section 1) or 2) below:

1) **AS THE EMPLOYER, I certify that individual named above is/was employed as a Certified Nurse Aide and worked FULL TIME from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ OR… Part Time/Per Diem for a total of _____ hours under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.**

_____ _____
Authorized Signature **Date**

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

(Place Notary Seal Here)

2) **AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a Nurse Aide Training and Competency Evaluation Program on _____; the Program was _____ hours.**

_____ _____
Authorized Signature **Date**

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

(Place Notary Seal Here)