

\*\*\*FOR OFFICE USE ONLY\*\*\*



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Receipt #

ID #

Issue Date

License #

## *Instructions and Application For*

# License As A Nursing Assistant

- By Examination
- By Testing for Nursing Students
- By RN or LPN License
- By Endorsement

DO NOT REMOVE THIS PAGE FROM APPLICATION

*Applicant - Print Name (First, MI, Last)*

# GENERAL INFORMATION

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## Enclosures

The following information is enclosed:

- Application Process Overview 3
- Instructions for Completing the Application 4
- Application Checklists 4
  - By Examination 4
  - By Testing for Nursing Students 5
  - By RN or LPN License 5
  - By Endorsement 5
- Application Form 6
- Interstate Verification Form 10
- Verification of Employment Form 11

## Statute

Chapter 23-17.9 entitled “Registration of Nursing Assistants” can be downloaded at the following website:

<http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm>

## Rules and Regulations

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

## Competency Examination

The Training Program Coordinator will schedule your test after you successfully complete the Nursing Assistant training program.

**You will be given three opportunities to successfully complete the Nursing Assistant examinations.** If you fail to give prior notice and do not arrive to take a scheduled test, it will count as a failed attempt. You may be employed as a trainee for 120 days. You must complete the testing process within one (1) year from the date you began the training program or you will be required to complete a new application and pay all fees.

## Initial License

Once you have passed your examinations, you will be notified. Your license may expire within a few months up to two years after your examination. You may need to renew your license prior to the normal two-year expiration period. Expiration dates are June 30th.

# GENERAL INFORMATION (CONTINUED)

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## Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to your license expiration date. You must obtain the signature of an official in a **licensed Rhode Island health care facility ONLY** (i.e. nursing home) where you were employed as a Nursing Assistant within the 24 months prior to renewal. **If you document that you were working in a facility other than a licensed Rhode Island health care facility, you will not be eligible for renewal.** **YOUR LICENSE MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER.**

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## APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, 3 Capitol Hill, Room 105, Providence, RI 02908.

## Application Process

You must submit the application and additional information. All items listed on the following applicable checklist must be submitted for an application to be considered complete. **APPLICATIONS ARE ONLY VALID FOR A ONE (1) YEAR PERIOD.**

If you previously had a license as a Nursing Assistant in Rhode Island, there are two ways to reinstate your license:

1. You must retrain and retest with a Rhode Island Nursing Assistant Training Program and follow the application instructions by Examination.
- Or
2. You are currently licensed in another state as a Nursing Assistant and have worked within the past two years and must follow the application instructions for Endorsement.

You are responsible for notifying HEALTH, in writing, when your address changes.

Once completed, the application will be reviewed and you will be contacted in writing. NOTE: You may ***not*** practice as a Nursing Assistant in Rhode Island until you have received your license.

***To obtain your licensure status and license number, please refer to the HEALTH Licensee Lookup website:***

<https://healthri.mylicense.com/Verification/>

If you have any questions about the application process, please contact this office at (401) 222-5888.

## 120 Day Temporary License

Applicants for Licensure by Examinaton and by Examination (Testing for Nursing Students) will be given a temporary license for 120 days. No extensions will be granted.

# INSTRUCTIONS FOR COMPLETING THE APPLICATION

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Read the following instructions carefully before you complete the application. **Only completed applications will be accepted.** Failure to submit all required information, appropriate documentation and required fee will result in processing delays.

## **General Instructions**

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Illegible information will not be accepted.
3. Provide a response to each section or question; otherwise, mark "N/A" for Not Applicable.
4. Make a copy of your completed application before you submit it to HEALTH.
5. It is your responsibility to check on the status of your application.

## **Completing your Application**

1. Complete the application. You must respond to all sections of the application as instructed. If you attach separate pages as a continuation of the application, please clearly indicate the section for which such information is being reported.
2. Make a check or money order payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first page of the application. The application fee is NON-REFUNDABLE.
3. Do not submit the application without all applicable information, documentation and fee. Mail the application to:

**Rhode Island Department of Health  
3 Capitol Hill, Room 105  
Providence, RI 02908-5097**

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## **APPLICATION CHECKLISTS**

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Please review the following checklists, **choose which one applies to you**, and include all of the required information to complete your Nursing Assistant application.

All applicants must include the following:

### **By Examination**

1. A passport-type 2 x 3 inch photograph, taken within 1 year;
2. Completion of Department approved Rhode Island Nursing Assistant training program;
3. Completion of written and practical Nursing Assistant examinations, within 1 year from the date you began the training program (given 3 opportunities to complete);
4. A \$40.00 non-refundable fee made payable to RI General Treasurer;
5. Original BCI check from the RI Attorney General's Office only, dated within 4 months (2 months for applicants who were licensed as a Nursing Assistant in Rhode Island) of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
6. Completed and notarized application; and

## APPLICATION CHECKLISTS CONTINUED

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### **By Testing for Nursing Students (If you are in a nursing program and completed 2 clinical courses)**

1. A passport-type 2 x 3 inch photograph, taken within 1 year;
2. Official transcript or signature of Dean of the School of Nursing;
3. Completion of written and practical Nursing Assistant examinations, within 1 year from the date you began the training program (given 3 opportunities to complete);
4. A \$40.00 non-refundable fee made payable to RI General Treasurer;
5. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
6. Completed and notarized application;

### **By RN or LPN License (If you are licensed as a RN or LPN)**

1. A passport-type 2 x 3 inch photograph, taken within 1 year;
2. Verification of current RN or LPN license;
3. A \$40.00 non-refundable fee made payable to RI General Treasurer;
4. Original BCI check from the RI Attorney General's Office only, dated within 4 months of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
5. Completed and notarized application;

### **By Endorsement (If you are licensed in another state and want to be licensed in RI)**

1. A passport-type 2 x 3 inch photograph, taken within 1 year;
2. Evidence of a current license as a Nursing Assistant in alternate jurisdiction;
3. A \$40.00 non-refundable fee made payable to RI General Treasurer;
4. Original BCI check from the RI Attorney General's Office only, dated within 4 months (2 months for applicants who were licensed as a Nursing Assistant in Rhode Island) of the application date, with stamp and seal; If positive BCI, a detailed explanation is required.
5. Completed and notarized application;
6. Completed Interstate Verification Form; and
7. Completed Verification of Employment Form, when applicable, which is the employer's statement that you have at least 3 months of full-time work experience as a Nursing Assistant.



**7. Preferred Mailing Address**

Please check ONE

- Please use my **Home Address** as my preferred mailing address.
- Please use my **Business Address** as my preferred mailing address.

**8A. Training Information**



Please list the name and information about the training that you participated in that qualifies you for this license.

Name of School/Training Program: \_\_\_\_\_

Address (Number and Street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

License Number of School/Training Program: \_\_\_\_\_

Date Class Began: \_\_\_\_\_ Date Graduated: \_\_\_\_\_

Month Day Year Month Day Year

Employment Date: \_\_\_\_\_ Test Site: \_\_\_\_\_

(If Applicable) Month Day Year Month Day Year

**Signature Required**



**EXAMINATION APPLICANTS** - Provide Signature of Training Program Coordinator.

\_\_\_\_\_  
Signature Title Date

\_\_\_\_\_  
Print or Type Name Phone

**8B. Training Information**



Please list the name and information about the training that you participated in that qualifies you for this license.

Type of School (University, College, Trade/Technical School etc.): \_\_\_\_\_

Name of School/Training Program: \_\_\_\_\_

Date of Completion of Qualifying Clinical Training: \_\_\_\_\_

Month Day Year

**NURSING STUDENT APPLICANTS** - Provide Signature (and Title) of School of Nursing Dean (or Designee).

*My signature below indicates and attests to the fact that the Nursing Student who has made this application to the Nursing Assistant Advisory Board has **completed a minimum of two (2) clinical courses**.*

**Signature Required**



\_\_\_\_\_  
Signature Title Date

\_\_\_\_\_  
Print or Type Name Phone

**Nursing Student Testing Information**

Nursing Students are required to successfully complete a written and practical examination to become licensed as a Nursing Assistant. Please review the Rhode Island Nursing Assistant Candidate Handbook, dated July 2008.

**PLEASE CALL CCRI's Lincoln Campus at (401) 333-7077 to schedule your examination.**



**12. Affidavit of Applicant**

Complete this section and sign in the presence of a notary public.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Nursing Assistant in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform HEALTH of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

The foregoing application was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did take an oath.

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

Notary Seal

\_\_\_\_\_  
Notary No/Commission No.

\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)

**13. Recent Photograph**

Securely tape or glue a passport type 2" x 3" photograph.



**Provide the date that the photograph was taken.**

\_\_\_\_\_  
Date of Photograph



Rhode Island Department of Health

3 Capitol Hill, Room 105
Providence, RI 02908-5097
(401) 222-5888

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S) (One form for each state)

I am applying for reinstatement to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Department of Health requires that this form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO THE OTHER STATE BOARD

Print/Type Full Name Signature Date
Previous Names Used Social Security Number Date of Birth
License Number Date Issued

THIS SECTION TO BE COMPLETED BY THE NURSING ASSISTANT BOARD

Directions for State Board: Please complete and return this form to the address above. Please verify requirements met in your state. If you answer "yes" to any of the questions, please explain on a separate sheet of paper and attach it to this form.

Licensed by Examination? If not by examination, how was license obtained?
Endorsement (State) Other (Explain)
Applicant has completed and passed the National Certification Exam: License Status: Original Date Issued: Expiration Date:
Score Level of Exam: Active Inactive Lapsed

Questions:

- 1. Has this applicant met all relevant state and federal requirements under OBRA '87 and '89 for Nursing Assistant Registration in the state of ?
2. Please indicate method and state approved training program in the state of
Date of Completion Number of hours
3. Competency Evaluation in state of Date of Completion OR Reciprocity/Endorsement
Registration in state of Other method (please explain):
4. Registration Number Issued Expiration
5. Has this licensee ever been investigated by your Board?
6. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending?
7. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?
8. Do you know of any information that may discredit this person?

Certification:

Signature Date
Type or Print Name
Title
Full Name of Licensing Board



Please return directly to the above address. Thank you for your prompt cooperation.



# Rhode Island Department of Health

3 Capitol Hill, Room 105  
Providence, RI 02908-5097  
(401) 222-5888

## NURSING ASSISTANT VERIFICATION OF EMPLOYMENT FORM

I am applying for a license to practice as a Nursing Assistant in the State of Rhode Island. The Rhode Island Department of Health requires that applicants for Rhode Island licensure must have this form verified and signed by their Employer/Employing Agency. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Department of Health at the above address.

**APPLICANT MUST COMPLETE THIS SECTION AND THEN SEND FORM TO EMPLOYER**

Print/Type Full Name	Signature	Date
Previous Names Used	Social Security Number	Date of Birth
License Number	Date Issued	

## THIS SECTION TO BE COMPLETED BY THE EMPLOYER/EMPLOYING AGENCY

The individual named above has made application to the Rhode Island Department of Health to become a Nursing Assistant.

This is to certify that \_\_\_\_\_ has completed three (3) months of full-time work experience as a Nursing Assistant.

Name of Employer/Employing Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Dates of Employment: From \_\_\_\_\_ To \_\_\_\_\_  
month/day/year month/day/year

### Additional Comments:

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### Certification:

Signature of Administrator/DNS	Date
Type or Print Name	Title

Acknowledgement:

By signing this form, I hereby affirm that my comments and answers to the above questions are true and complete to the best of my knowledge

*Please return directly to the above address. Thank you for your prompt cooperation.*