FOR OFFICE USE ONLY

Date Received

☐ PW	______	☐ PP	______
☐ FW	______	☐ FP	______
☐ FW	______	☐ FP	______
☐ FW	______	☐ FP	______

Receipt #

ID #

Issue Date

License #

OFFICE USE ONLY

Checklist

☐ Fee ☐ Tax ☐ Verification(s) ___ ___

☐ BCI ☐ Employment ☐ Out-of-State of License(s) ___ ___

☐ Photo ☐ Training

Instructions and Application For

License As A Nursing Assistant

☐ By Examination

☐ By Testing for Nursing Students

☐ By RN/LPN

DO NOT REMOVE THIS PAGE FROM APPLICATION

Applicant - Print Name (First, MI, Last)

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-3352**

Revised 06/06/2008 maa

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Application Process Overview.. 4

Instructions for Completing Application... 5

Application Checklist.. 6

Application... 7-10

Mandatory Addendum to License Application (Social Security Number Verification).................... 13

Licensure Requirements

All Applicants

- Recent passport type photograph (no photocopies).
- A Full Bureau of Criminal Investigation (BCI) Check.
- In addition to requirements listed under “**All Applicants**” (above):
- Processing Fee: **$40.00** Paid by Applicant (covers application processing and intial license).

By Testing For Nursing Students

- In addition to requirements listed under “**All Applicants**” (above):
- Processing Fee: **$40.00** Paid by Applicant (covers application processing and intial license).
- Official Transcript **OR** Signature (and Title) of the Dean of Nursing (or Designee).

By RN/LPN

- In addition to requirements listed under “**All Applicants**” (above):
- Processing Fee: **$40.00** Paid by Applicant (covers application processing and intial license).
- Provide a copy of your **current** RN/LPN license.

Temporary Licenses - (120 Day)

- For “Licensure by Examinaton” or “Testing for Nursing Students” **ONLY.** Issued for a period of 120 days, with no extensions granted.

Rules and Regulations/Laws

The “Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants and the Approval of Nursing Assistant Training Programs (R23-17.9-NA)” can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/DOH/DOH_3097.pdf

Chapter 23, Title 17.9 entitled “Registration of Nursing Assistants” can be downloaded at the following web site:

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

GENERAL INFORMATION (CONTINUED)

Competency Examination

The Program Coordinator will schedule your test after you successfully complete the Nursing Assistant Training program. This test will be at one of the state test sites.

You will be given three opportunities to successfully complete the Competency Evaluation. Retests will be conducted at the same site as the original test. Reminders - 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: first day of employment to registration/licensure. - You must complete testing process within one (1) year from the date of initial training; or, you must be retrained and complete a new application and pay all fees once again.

Initial License

Once you have passed your examinations, you will be issued your initial license. Please note: that license may expire within a few months up to two years after your examination. Expiration dates are randomly assigned. Depending upon your expiration date, you may need to renew your license prior to the normal two-year expiration period.

Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to the license expiration date. You must obtain the signature of an official in a **licensed health care facility** (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 health care facility, you will not be eligible for renewal.** **YOUR REGISTRATION MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER.**

In-Service

Your employer must provide you with 12 hours of in-service per year, which you will be required to attend.

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Nursing Assistant Advisory Board (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 6) must be submitted for an application to be considered complete. **"APPLICATIONS ARE VALID FOR A ONE (1) YEAR PERIOD".**

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have a malpractice, criminal or disciplinary history in Rhode Island, or another state, it can take an additional 2 or 3 months for processing your application.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The BOARD may be emailed an address change. The email address is located at the following web site:

http://www.health.ri.gov/hsr/professions/n_assist.php

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

http://www.health.ri.gov/hsr/professions/license.php

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5888.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may 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. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark “N/A” for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. t is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (7-10 and 11). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **$40.00** payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
3. Complete all application materials as instructed and arrange them in the order listed on the application check-list (page 6). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

Rhode Island Department of Health
Nursing Assistant Advisory Board
Room 105, 3 Capitol Hill
Providence, RI 02908-5097

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the application as instructed (pages 7-10 and 11).
- ☐ I have completed Section 12, **"Affidavit of Applicant"**, and have had the affidavit section completed and notarized by a notary public.
- ☐ I have attached a photograph to Section 13, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the amount of **$40.00** and attached it to the upper left-hand corner of the first (Top) page of the application (All fees are NON-REFUNDABLE).
- ☐ I have arranged my Board Application materials in the following order.
    1. Fee (attached as instructed).
    2. Board Application (**including cover page**) (pages 7-10 and 11).
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] MUST indicate the section for which the information is being reported.]
- ☐ I have mailed the above application materials directly to the Rhode Island Nursing Assistant Advisory Board.

Nursing Students Only

- ☐ I have provided the Signature (and Title) of the Dean of the School of Nursing or Designee (Nursing Students);

RN/LPN Applicants Only

- ☐ I have provided a copy of my current RN/LPN license as requested.

Additional Requirement for ALL CANDIDATES

- ☐ I have requested a full Bureau of Criminal Investigation check (BCI) from the Attorney General's Office, 150 South Main Street, Providence, RI 02903 - (401) 274-4400 as instructed. **If you answer yes to question 10 on page 8, and you do not provide a complete explanation describing your criminal activity, your application will not be processed. If you do not pass both examinations within six (6) months from the date of the BCI, a current BCI will need to be submitted before you will be licensed.**

REMOVE THIS PAGE

State of Rhode Island
Nursing Assistant Advisory Board
Application for License as a Nursing Assistant

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).

____

____

2. Social Security Number

– –

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 1 9

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S.

Postal Code, If NOT U.S.

Home Phone –

Home Fax –

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S.

Postal Code, If NOT U.S.

Business Phone –

Extension

Business Fax –

Applicant: Print your complete last name >

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: Month Day Year | Date Graduated: Month Day Year

Test Site: ______

Employment Date: (If Applicable) Month Day Year | Test Date: Month Day Year

Signature Required

EXAMINATION APPLICANTS - Provide Signature of Training Program Coordinator.

Signature | Title | Date

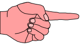
Print or Type Name | Phone

8B.Training Information

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

Name of School/Training Program

Date of Completion of Qualifying Clinical Training: Month Day Year

Signature Required 

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

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 | Title | Date

Print or Type Name | Phone

Nursing Student Testing Information

You **MUST** coordinate testing with the Board.

NURSING STUDENT APPLICANTS - Nursing Students are required to complete and pass a State Examination (written and practical) to become licensed as a Nursing Assistant.

PLEASE NOTE: The Test Site telephone number is provided for applicants to check test schedule/availability only! TEST ENROLLMENT MUST BE COORDINATED with the Nursing Assistant Advisory Board.

To coordinate with the Nursing Assistant Advisory Board, a "Nursing Assistant Competency Evaluation" form will be sent to you upon submission of this license application.

PLEASE CALL CCRI - Lincoln at (401) 333-7077 to schedule your Examination

9. Original (and Other) State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, list the license number(s) of the original state (and any other states) of licensure below:

Original Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

Other State Licensure

State | License Number

10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? **If you answer yes and you do not provide an explanation, your application will not be processed. If you do not pass both examinations with six (6) months from the date of the BCI, a current one will need to be submitted.** ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance): Month Year

If you answer yes, you must give complete details as to what led to the arrest(s).

11. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. If you answer "Yes" to any question you **must** attach originals, or certified copies of any court documentation to this application.

12. Affidavit of Applicant

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

Make sure that you and the notary public have completed all components accurately and completely.

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 my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Nursing Assistant Advisory Board 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 instrument was acknowledged before me this _____________ day of

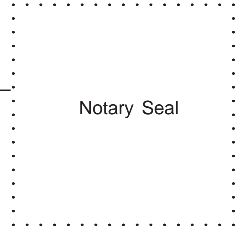
___________________, 20_______, by ___________________________________,

who is personally known to me or has produced ____________________________

as documentation and did / did not take an oath.

____________________________________ Name of Notary (Print, Type or Stamp)

____________________________________ Signature of Notary



__________________________ Notary No/Commission No.

____________________________ Commission Expiration Date (MM/DD/YY)

13. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

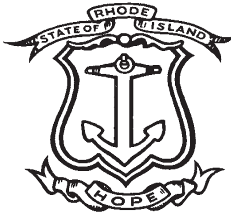
Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Write your name on the back of the photograph, and provide the date that the photograph was taken.

______________________________ Date of Photograph

PLEASE CHECK ONE BOX ONLY, EVEN IF YOU HAVE NEVER BEEN EMPLOYED IN RHODE ISLAND.



Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- ☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- ☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- ☐ I am currently pursuing administrative review of taxes owed to the state.
- ☐ I am in federal bankruptcy. (Case #____________________)
- ☐ I am in state receivership. (Case #____________________)
- ☐ I have been discharged from bankruptcy. (Case #____________________)

____

Type of Professional License for which you are applying.

____________________	____________________
Full Name (Please Print or Type)	Social Security Number
____________________	____________________
Signature	Phone Number (including area code if not 401)
____________________	
Date	

This form must be completed, signed and attached to your license application for processing.