

New York State Nursing Home Nurse Aide Registry Application

Section 1. Candidate Information: MUST be completed by all applicants.



Note: Before you enter your name below, check the government issued identification that you will use for admission to testing. If the name you use below does not match the name on the identification you provide on the day of testing, you will not be allowed to take your exam.

facility. I will give this application form to the facility coordinator (do not send it to Prometric). Regional Test Site: I am applying to take my exams at a Regional Exam Site. I will receive an admission letter with my specific exam date, time and location. First Choice Exam Site: Second Choice Exam Site: Second Choice Exam Site: Agreement of Authorization, Confidentiality, and Release Statement I agree that the New York State Division of Residential Care and Service may investigate the information in this application. I understand that exam results will be sent to my approved training program and/or employing nursing home (when applicable). I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by New York State. Further, I understand that if I cheat or engage in other prohibited behavior during the exam I may be disqualified from continuing to take the exam or my exam results may be invalidated. I understand that a record of the successful completion of this competency evaluation and information from and contained on this form will be included in my record in the New York State Nursing Home Nurse Aide Registry. I have read and I understand the information in the New York State Nursing Home Nurse Aide Certification Handbook.					•							
City State ZIP Code County State ZIP Code County	Last	: Name		Fi	rst Name		Middle Name	Other/Maiden Nan	ne (if appli	icable)		
Home Phone Number (Including area code) (Street Address (including Apt. number or P.O. Box, if applicable)		_ · · · · · · · · · · · · · · · · · · ·						
Social Security Number	City	*	***************************************	***************************************		State	ZIP Code		мае	***************************************		
Social Security Number	Hom	ne Phone Numbe	r (includir	na area codo		***************************************	***************************************					
Current Nursing Home Employment Status: Full Time	()	(meidan	ig area code,	*	Email Address						
Current Nursing Home Employment Status:	Soci	al Security Numl	per	· · · · · · · · · · · · · · · · · · ·	18800000 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Date of	Birth		******************************	1006/12/2014/00/00/00/00/00/00/00/00/00/00/00/00/00		
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Do you currently hold a certification as a nurse aide or are you listed on the nurse aide registry in any state other than New York? I fees, list all the states below and indicate if you are in good standing on the Registry in that state. Good standing means that you have no findings or convictions of resident abuse, neglect or misappropriation of resident belongings. Add an additional sheet of paper if more space is required. Issuing State Good standing? Issuing State Good stan	Curr (If y	ent Nursing Hon ou are currently	ne Employ working i	ment Status n a nursing l	: Full Time Pa		Per Dier	n Not Employed	<u></u>	* - 2		
Yes No No Yes No No Route 1. New Nurse Aides Route 2. Reciprocity/CNA From Another State Route 3. Graduate Nurses Route 4. RNs and LPNs licensed in the U.S.: Enter RN/LPN License Number: Route 5. Foreign-Trained Nurses Route 6. Trained and Lapsed: Enter NYS Nurse Aide Certificate Number: Route 7. Lapsed-Other: Enter NYS Nurse Aide Certification Number: Exam Site Information (Check one of the following options.) In-facility Site: My employer or training program is scheduling my exams and I will take the exams at their facility. I will give this application form to the facility coordinator (do not send it to Prometric). Regional Test Site: I am applying to take my exams at a Regional Exam Site. I will receive an admission letter with my specific exam date, time and location. First Choice Exam Site: Second Choice Exam Site: Second Choice Exam Site: Second Choice Exam Site: I all applications. Agreement of Authorization, Confidentiality, and Release Statement I agree that the New York State Division of Residential Care and Service may investigate the information in this application. I understand that exam results will be sent to my approved training program and/or employing nursing home (when applicable). I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by New York State. Further, I understand that if I cheat or engage in other prohibited behavior during the exam I may be disqualified from continuing to take the exam or my exam results may be invalidated. I understand that in a record of the successful completion of this competency evaluation and information from and contained on this form will be included in my record in the New York State Nursing Home Nurse Aide Certification Handbook. I understand that I may be asked to play the part of the resident for an	Do y othe in th misa	you currently hole or than New York nat state. Good s appropriation of a	d a certifion If yes, lind Itanding material Tesident b	cation as a n ist all the sta neans that yo elongings. A	urse aide or are you lis ites below and indicate ou have no findings or o dd an additional sheet	sted on the if you are conviction of paper	ne nurse aide re in good star ns of resident if more space	registry in any state	Yes	□ No		
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Signature of Applicant	6	I understand that I may be asked to play the part of the resident for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the New York State Department of Health, and their agents and assigns from any responsibility or liability for any claim or							ve any at I am			
	Sign	ature of Applicar	nt						Date	***************************************		

Section 3. Optional Applicant Information. Education Level (Check the box next to your highest education level completed. Check only one box,) ☐ 4th grade or less High School diploma or GED ☐ Two-year college degree ☐ Between 5th and 8th grades ☐ Trade or Technical School Certificate ☐ More than two years college, no degree ☐ Some High School, did not ☐ One or two years college, ☐ Four-year college degree or more graduate no degree Ethnic Group (Check only one box.) American Indian or Alaskan Native ☐ Mexican American Other: ☐ Asian American/Pacific Islander ☐ Other Hispanic or Latin American ☐ Black/African American ☐ White Section 4. MUST be completed by your employer. (This section must be completed by your employer if you are employed in NYS by a Health Care Provider with a Nurse Aide Employer Facility Code.) Employer Facility Code Number: Date of Hire: (MONTH/DAY/YEAR) What Type of Nurse Aide Employer is the Facility? Nursing Home ☐ Home Health Agency ☐ Hospital ☐ Staff Agency Other ! Name of Facility or Agency Where Employed Address of Employer City State ZIP Code Employer's Signature Date Section 5. MUST be completed by the training program coordinator. (This section must be completed for any applicant who has checked Certification Routes 1, 3, 5 or 7.) Training Program Code Number: Expected Program Completion Date: 3 3 (MONTH/DAY/YEAR) Name of Nurse Aide Training Program Training Program Mailing Address City State ZIP Code

Section 6. Fees.

Training Program Coordinator/Instructor Signature

Exam Title	Exam Fee	Total
Clinical Skills AND Written exams (first-time tester)	\$115	\$
Clinical Skills AND Oral exams (must have ADA paperwork)	\$115	T +
Clinical Skills AND Oral exams	\$135	1 P
Clinical Skills Retest (Prometric ID number)	\$68	4 4
Written Retest (Prometric ID number)	\$57	'
Oral Retest (Prometric ID number)	\$67	Т
Additional Services	Fee	7
Reciprocity/CNA From Another State and NYS RNs and LPNs Application Processing	\$50	\$
Duplicate Score Report	\$15	T
Hand Score Report	\$25	
	Total	\$

Date

This exam taker has successfully completed a state-approved Nurse Aide Training Program.

Payment: Fee(s) may be paid by money order or certified check made payable to "NY Commissioner of Health, NYNA." Your name and ID (if available) must be written on the form of payment. Personal checks and cash are not accepted. Fees are nonrefundable. Mail to: Prometric, ATTN: NY Nurse Aide Program, 7941 Corporate Drive, Nottingham, MD 21236.