Nursing Assistant Certification Endorsement Application Packet

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2. 667-030 ....Application Instructions Checklist..................................................5 pages
3. 667-031 ....Nursing Assistant Certification Application ......................................4 pages
4. 667-005 ....Out-of-State Credential Verification Form .................................1 page
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Important Social Security Number Information:
You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please read, complete, and return this form with your application.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:
Mail your application with initial documentation and your check or money order payable to:  

Department of Health  
P.O. Box 1099  
Olympia, WA  98507-1099

Send other documents not sent with initial application to:

Nursing Assistant Credentialing  
P.O. Box 47877  
Olympia, WA  98504-7877

Contact us:
360-236-4700
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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

☐ Application Fee. This fee is non-refundable. You can check the online fee page for current fees.

☐ Check one that applies:
Check which type of training you have completed.

☐ Check if either apply:
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ 1. Demographic Information:
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state and country where you were born.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See WAC 246-12-310.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.
Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ 2. Personal Data Questions:
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.

- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ 3. Caregiver Employment History (to be completed by endorsement applicants):
List the last place of caregiver employment with its address, the first and last days of employment, and the last two states where your name appears on the OBRA registry.

☐ 4. Certifying Organization (to be completed if applying by medical assistant as an alternative training):
If you are applying as a certified medical assistant, select which organization you hold a current certification with.

☐ 5. Other License, Certification, or Registration:
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

☐ 6. AIDS Education and Training Attestation:
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in WAC 246-12-270.

☐ 7. Applicant’s Attestation:
You must sign and date this for us to process the application.
Certification Requirements

To be eligible to apply for nursing assistant certification you must:

• Submit application and fee
• See the list of approved programs.
  Have your school send official transcripts directly to the Department of Health.
• Have completed a cardiopulmonary resuscitation (CPR) course; and
• Have successfully completed the nurse aide competency evaluation.

Alternative Training

Successful completion of an approved alternative program and the nurse aide competency evaluation may allow the certified home care aide or certified medical assistant to meet the requirements to become a certified nursing assistant.

If you are a certified home care aide seeking nursing assistant-certification, refer to WAC 246-841-545 alternative program requirements.

If you are a certified medical assistant seeking nursing assistant-certification, refer to WAC 246-841-550 alternative program requirements.

To become certified as a nursing assistant through alternative training you must meet the following requirements:

• Submit application and fee
• Be currently certified as a home care aide under chapter 18.88B RCW;
  - Provide a copy of certificate of completion from an approved alternative program for certified home care aides.
  - Provide documentation verifying current certification as a home care aide.

OR

• Be a certified medical assistant who holds a current certification from one of the certifying organizations listed in WAC 246-827-0200(2).
  - Provide proof of completion from one of the following organizations:
    - American Association of Medical Assistants (AAMA);
    - American Medical Technologists (AMT);
    - National Healthcareer Association (NHA);
    - National Center for Competency Testing (NCCT).
  - Provide a copy of certificate of completion from an approved alternative program for certified medical assistant;
  - Provide an official transcript from the nationally accredited medical assistant program you completed;

Transcripts: Have your school send official school transcripts directly to the Department of Health.

• Have completed a cardiopulmonary resuscitation (CPR) course, provide a copy of the front and back of your current card as proof of completion; and
• Have successfully completed the nurse aide competency evaluation. Graduates of alternative programs who meet all application requirements are deemed eligible to complete the nurse aide competency evaluation approved by the Nursing Care Quality Assurance Commission.
Military training, out of state training, out of country training, or nursing school student:
If you have completed one of the above listed trainings (and do not have an out of state certification) you must:

- Submit application and fee
- Have your training program submit official transcripts, certificates, or any documentation of training;
- Have completed a cardiopulmonary resuscitation (CPR) course, provide a copy of the front and back of your current card as proof of completion;
- Have successfully completed the nurse aide competency evaluation

**Note:** Once your training has been reviewed, if it meets Washington State requirements, you will receive a letter that will be needed in order to schedule your exam. Once you have successfully passed your exam, results will be sent directly to the department.

**Instructions for Nursing Assistant Certification by Interstate Endorsement**
If your name is listed on another state registry and you hold an active credential in another state, you may qualify for Interstate Endorsement as a Certified Nursing Assistant in Washington State.

You may apply for state certification by completing the following requirements:

- Application for Nursing Assistant Certification by Interstate Endorsement. Complete Section 1, 2, 3, 5 and 6. In section three, the last date of employment is required, if you have no employment history mark this as not applicable (N/A). If this is left blank, it could delay the processing of your application. Check the correct box for Nursing Assistant Certification by Interstate Endorsement.
- Complete the top portion of the Out-of-state Verification Form and send it to the state you are coming from. That state will complete the bottom portion of the Verification Form and mail it directly to Washington State. Contact information for other states can be found on the Out of State NAC Registries.

**Other Information**
Criminal history checks are conducted for all license applicants. If you answered yes to any of the personal data questions, please submit the appropriate supporting documentation as indicated on the application. If your application is incomplete, you will be mailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Write N/A or place a line through the section instead of leaving blank.
- The initial certification will expire on your birthday unless the initial certification is issued within 90 days of your next birthday.
- A courtesy renewal notice will be mailed to your address on record. You must keep your address current with us. Any renewal postmarked or presented to the department after midnight on the expiration date is late.
- Information regarding the nursing assistant program is available on our Website.
For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.
  
  **Please note:**
  - A copy of your DD214 can be downloaded from the EBenefits website.
  - You can request a replacement copy of your NGB-22 on the National Archives website.
- Official Joint Service Transcript (JST) or Community College of the Air Force (CCAF) Transcripts.
  
  **Please note:**
  - JST can be sent electronically by visiting the JST website and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the CCAF website for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the DoDTAP website.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the Military Resources website.
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### Nursing Assistant Certification Endorsement Application

**Check One:**
- [ ] Nursing Assistant Certification by approved Nursing Assistant Program
- [ ] Nursing Assistant Certification by Interstate Endorsement
- [ ] Nursing Assistant Certification by Alternative Training Program
- [ ] Military Training
- [ ] Out of State Training
- [ ] Out of Country Training
- [ ] Nursing Student

**Select if either apply:**
- [ ] Request for Military Training and Experience Evaluation
- [ ] Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<table>
<thead>
<tr>
<th>Social Security Number (SSN)</th>
<th>National Provider Identifier Number (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you do not have a SSN, see instructions)</td>
<td>(Enter 10 digit number)</td>
</tr>
</tbody>
</table>

Name  
First  
Middle  
Last

Birth date (mm/dd/yyyy)

<table>
<thead>
<tr>
<th>Place of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

Country

<table>
<thead>
<tr>
<th>Phone (enter 10 digit #)</th>
<th>Fax (enter 10 digit #)</th>
<th>Cell (enter 10 digit #)</th>
</tr>
</thead>
</table>

Email address

Mailing address (if different from above)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

### Note:
The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?  
- [ ] Yes  
- [ ] No

If yes, list name(s):

Will documents be received in another name?  
- [ ] Yes  
- [ ] No

If yes, list name(s):
2. Personal Data Questions

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.

   “Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   **Note:** If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.

   “Currently” means within the past two years.

   “Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?

4. Are you currently engaged in the illegal use of controlled substances?

   “Currently” means within the past two years.

   **Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   **Note:** If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?

   **Note:** If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.
2. Personal Data Questions (cont.)

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend
      drugs in any way other than for legitimate or therapeutic purposes? ................................................... ☐  ☐
   b. Diverted controlled substances or legend drugs? ................................................................................. ☐  ☐
   c. Violated any drug law? ........................................................................................................................... ☐  ☐
   d. Prescribed controlled substances for yourself? ....................................................................................... ☐  ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule
   regulating the practice of a health care profession? If “yes”, please attach an explanation and
   provide copies of all judgments, decisions, and agreements? ................................................................. ☐  ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care
   profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ............. ☐  ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to
   avoid action by a state, federal, or foreign authority? ................................................................................ ☐  ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence,
    negligence, or malpractice in connection with the practice of a health care profession? ....................... ☐  ☐

11. Have you ever been disqualified from working with vulnerable persons by the Department
    of Social and Health Services (DSHS)? .................................................................................................... ☐  ☐

3. Caregiver Employment History
(to be completed by endorsement applicants only)

<table>
<thead>
<tr>
<th>Last Place of Caregiver Employment</th>
<th>First/Last Days of Employment</th>
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<tr>
<td></td>
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</table>

Address of Last Place of Caregiver Employment

List the Last Two States Where Your Name Appears on the OBRA Registry

1. __________________________________________  2. __________________________________________

4. Certifying Organization
(to be completed if applying by medical assistant as an alternative training)

If you are applying as a certified medical assistant, select which organization you hold your current
certification with.

☐ American Association of Medical Assistants (AAMA);
☐ American Medical Technologists (AMT);
☐ National Healthcareer Association (NHA);
☐ National Center for Competency Testing (NCCT).
5. Other License, Certification, or Registration

List all states, including Washington, where any health care credentials are or were held. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

<table>
<thead>
<tr>
<th>State/jurisdiction</th>
<th>Profession</th>
<th>Certificate Year</th>
<th>Number</th>
<th>Permanent or Temporary</th>
<th>License Received Exam</th>
<th>Other</th>
<th>Currently in force</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>No □ Yes</td>
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<td>No □ Yes</td>
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<td>No □ Yes</td>
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<td></td>
<td>No □ Yes</td>
<td></td>
<td>No □ Yes</td>
</tr>
</tbody>
</table>

6. AIDS Education and Training Attestation

I certify I have completed a minimum of seven hours of education in the prevention, transmission, and treatment of AIDS. The education was through my professional education or through the completion of DSHS required training for caregivers or staff employed by DDD Certified Residential Programs. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.

AIDS training may include self study, direct patient care, online courses, or formal training.

Applicant’s initials | Date

7. Applicant’s Attestation

I, ________________________________________, declare under penalty of perjury under the laws of the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ___________________________________ at ___________________________________

By: ________________________________________

(DOH 667-031 March 2016)
### Part I: To Be Completed By Applicant

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am listed on the Nurse Aide Registry in the state of</td>
<td></td>
</tr>
<tr>
<td>and my registration number is</td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
</tr>
<tr>
<td>I completed a nursing assistant training program at</td>
<td></td>
</tr>
<tr>
<td>Training Site</td>
<td></td>
</tr>
<tr>
<td>mm/dd/yyyy</td>
<td></td>
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<tr>
<td>I completed a competency examination on</td>
<td></td>
</tr>
<tr>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
<tr>
<td>I became a nursing assistant by waiver or deeming.</td>
<td></td>
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<tr>
<td>I am applying in Washington under the name of</td>
<td></td>
</tr>
<tr>
<td>Last recorded place of caregiver employment</td>
<td></td>
</tr>
<tr>
<td>Starting and ending date of caregiver employment</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

Nurse Aide: Do not return this form to the Washington Nurse Aide Registry. After you have completed the information requested above, it is your responsibility to send this form to the state agency from which you completed your nurse aide training and testing.

### Part II: To Be Completed By State Agency

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>The information on this form is accurate and the above-named person is</td>
<td></td>
</tr>
<tr>
<td>on the nursing assistant registry in our state.</td>
<td></td>
</tr>
<tr>
<td>The above-named person is not on the nursing assistant registry in our</td>
<td></td>
</tr>
<tr>
<td>Date of Registration or Certification mm/dd/yyyy</td>
<td></td>
</tr>
<tr>
<td>Date of Expiration of Registration or Certification mm/dd/yyyy</td>
<td></td>
</tr>
<tr>
<td>Has Registrant had any type of disciplinary action?</td>
<td></td>
</tr>
<tr>
<td>If yes, please explain:</td>
<td></td>
</tr>
<tr>
<td>Is Registrant currently under investigation?</td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
<tr>
<td>Title</td>
<td>State</td>
</tr>
</tbody>
</table>
RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130
Administrative Procedure Act, RCW 34.05
Administrative Procedures and Requirements, WAC 246-12
Nursing Assistants Laws, RCW 18.88A
Nursing Assistants Rules, WAC 246-841

Online

AIDS Training Resources, Reference Page
Nursing Assistant Program webpage
List of State Nursing Registries