INSTRUCTIONS:

➢ Review Part 1 below and determine if you meet the eligibility requirements to be listed on the North Carolina Nurse Aide I Registry.
➢ If you meet the eligibility requirements, then complete and submit all pages of the application and any required supportive documentation by mail or fax.
   - Mailing Address: 2709 Mail Service Center, Raleigh, NC 27699-2709
   - Fax Number: 919-733-9764

Do Not Submit More Than One (1) Application Unless Instructed by DHSR.

PART 1: DETERMINE ELIGIBILITY

Consistent with Rule 10A NCAC 13O .0301, to be eligible to be listed on the North Carolina Nurse Aide I Registry, you must meet the five criteria listed below.

1. You are listed on another State’s registry of nurse aides as active and in good standing.
   - Temporary listings on State registries of nurse aides will not be accepted.

2. You have no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on other State registries of nurse aides.

3. In the past 2 years, you have been employed as a nurse aide for monetary compensation and worked at least a total of 8 hours performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse.
   - If you have not been employed as a nurse aide, then you are only eligible for reciprocity if you successfully passed a state-approved nurse aide I competency examination and was listed on the Nurse Aide I Registry in the State(s) of reciprocity in the past 2 years.
   - Private duty nurse aide employment type does not meet the eligibility requirements for reciprocity.

4. You have a social security card and an unexpired government-issued identification containing a photograph and signature.
   - The name listed on your social security card and unexpired government-issued identification containing a photograph and signature must match the name listed on the nurse aide registry in the State(s) of reciprocity. If the names do not match, then you must submit documentation verifying any name changes (e.g., birth certificate, marriage license, divorce decree, notice of resumption of former name, etc.).

5. You completed a state-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a state-approved competency evaluation program that meets the requirements of 42 CFR 483.154.
PART 2: PERSONAL INFORMATION

- Print legibly.
- Include hyphens and suffixes in your legal name if applicable (No Nicknames).

**First Name:**

**Middle Name:**

**Last Name:**

**Prior Name(s) (if applicable):**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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</table>

**Gender:**

- [ ] Male  - [ ] Female

**Social Security Number:** (include all 9 numbers)

**Email Address:**

**Telephone Number:** (include area code)

**Date of Birth:**

- [ ] mm/dd/yyyy

**Mother’s Maiden Name:**

**Mailing Address:**

<table>
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<tr>
<th>Street/PO Box</th>
<th>Apt. #</th>
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<th>City</th>
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<table>
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<tr>
<th>Zip Code</th>
<th>County</th>
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</table>

PART 3: STATE-APPROVED NURSE AIDE I TRAINING & COMPETENCY EVALUATION PROGRAM

Answer both questions below.

- [ ] YES  - [ ] NO  Did You Complete a State-Approved Nurse Aide I Training Program that Consisted of At Least 75 Hours of Training?

- [ ] YES  - [ ] NO  Did You Successfully Pass a State-Approved Nurse Aide I Competency Examination?
PART 4: NURSE AIDE I REGISTRIES

- Complete the table and questions below.
- List all states that you have an active or expired nurse aide I registry listing. We will verify that you have no findings in the states where your listing is active or expired.
- For all active listings, you must include, with this application, documentation verifying that each registry listing is active and in good standing in the State of reciprocity. The documentation should be dated within 30 calendar days before the date your application is received by the Department.
- If your listing is active in the state of Alabama, then you must submit a letter from your current or former employer, on official company letterhead, indicating your nurse aide status is active in the state of Alabama.

<table>
<thead>
<tr>
<th>State Name or Abbreviation:</th>
<th>Is Your Listing Current/Active?</th>
<th>Original Issue Date: mm/dd/yyyy</th>
<th>Expiration Date: mm/dd/yyyy</th>
<th>Certification or Registration Number:</th>
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<tbody>
<tr>
<td>□ YES □ NO</td>
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<tr>
<th>State Name or Abbreviation:</th>
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<tr>
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<tbody>
<tr>
<td>□ YES □ NO</td>
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</table>

- □ YES □ NO Are You Listed on More Than 4 State Nurse Aide Registries in an Active or Expired Status?

If YES, Then You Must Attach a Separate Sheet of Paper Providing the Registry Information for the States Not Listed in the Table Above.

- □ YES □ NO Do You Have Any Pending or Substantiated Findings of Abuse, Neglect, Exploitation, or Misappropriation of Resident or Patient Property Recorded on Any State Registry of Nurse Aides?

If YES, Then List All State(s) That Apply: ________________________________________________________________
______________________________________________________________

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PART 5: EMPLOYMENT HISTORY

Select the employment type where you performed nursing or nursing-related tasks delegated and supervised by a Registered Nurse in the past 2 years. Private duty nurse aide employment does not meet the eligibility requirements for reciprocity.

Select all that apply.

☐ Adult/Family Care Home  ☐ Hospital  ☐ Home Health/Home Care

☐ Hospice  ☐ Mental Health  ☐ Nursing Home

☐ Other (please specify): _____________________________________________

☐ I Did Not Work as a Nurse Aide; I Successfully Passed a State-Approved Nurse Aide I Competency Evaluation Program and Was Listed on the Nurse Aide I Registry in the State(s) of Reciprocity in the Past 2 Years.

Provide employer information where you performed nursing or nursing-related tasks delegated and supervised by a Registered Nurse in the past 2 years. Do not include private duty nurse aide employment.

If you did not work as a nurse aide, then leave blank.

FACILITY/AGENCY/EMPLOYER #1

Name: ____________________________________________________________

Street/PO Box: ____________________________________________________________________________

City: _____________________________ State: _________ Zip Code: ______________

Date of Hire as a Nurse Aide: _____/_______ mm yyyy  Last Reported Date of Employment as a Nurse Aide (if currently employed use today’s date): _____/_______ mm yyyy

☐ YES ☐ NO Is This Employer a Staffing Agency?

If YES, Then List All States Where Your Worked as a Nurse Aide for the Staffing Agency (e.g., New York, Georgia, etc.): ________________________________________________________________

______________________________________________________________

☐ YES ☐ NO Did You Work as a Nurse Aide for Monetary Compensation?

☐ YES ☐ NO If YES, Did You Work At Least a Total of 8 Hours Performing Nursing or Nursing-Related Tasks Delegated and Supervised by a Registered Nurse?

If YES, Provide the First Name and Last Name of the Registered Nurse Only:

First Name: ___________________________ Last Name: ___________________________
FACILITY/AGENCY/EMPLOYER #2

Name: ____________________________________________

Street/PO Box: ______________________________________

City: ____________________________________________    State: _________    Zip Code: __________

Date of Hire as a Nurse Aide: _____/_______    Last Reported Date of Employment: _____/_______
    mm    yyyy                                      mm    yyyy

□ YES  □ NO  Is This Employer a Staffing Agency?

If YES, Then List All States Where You Worked as a Nurse Aide for the Staffing Agency (e.g., New York, Georgia, etc.):

________________________________________________________________________________

□ YES  □ NO  Did You Work as a Nurse Aide for Monetary Compensation?

□ YES  □ NO  If YES, Did You Work At Least a Total of 8 Hours Performing Nursing or Nursing-Related Tasks Delegated and Supervised by a Registered Nurse?

If YES, Provide the First Name and Last Name of the Registered Nurse Only:
    First Name: _________________________    Last Name: __________________________________

FACILITY/AGENCY/EMPLOYER #3

Name: ____________________________________________

Street/PO Box: ______________________________________

City: ____________________________________________    State: _________    Zip Code: __________

Date of Hire as a Nurse Aide: _____/_______    Last Reported Date of Employment: _____/_______
    mm    yyyy                                      mm    yyyy

□ YES  □ NO  Is This Employer a Staffing Agency?

If YES, Then List All States Where You Worked as a Nurse Aide for the Staffing Agency (e.g., New York, Georgia, etc.):

________________________________________________________________________________

□ YES  □ NO  Did You Work as a Nurse Aide for Monetary Compensation?

CONTINUED ON NEXT PAGE
☐ YES  ☐ NO  If YES, Did You Work At Least a Total of 8 Hours Performing Nursing or Nursing-Related Tasks Delegated and Supervised by a Registered Nurse?

If YES, Provide the First Name and Last Name of the Registered Nurse Only:

First Name: _________________________  Last Name: __________________________________

NOTE:
You must attach a separate sheet of paper if you had more than 3 employers where you performed nursing or nursing-related tasks delegated and supervised by a Registered Nurse in the past 2 years. Do not include private duty nurse aide employment.

PART 6: IDENTIFICATION

▪ Include a copy of your social security card and an unexpired government-issued identification containing a photograph and signature with the submission of your application.

▪ The name listed on your social security card and unexpired government-issued identification containing a photograph and signature must match the name listed on the nurse aide I registry in the State(s) of reciprocity. If the names do not match, then you must submit documentation verifying any name changes (e.g., birth certificate, marriage license, divorce decree, notice of resumption of former name, etc.).

▪ Copies of identifications received by fax may not be readable. Please ensure copies of your identifications are readable before submitting your application. If your identifications are not readable, then you will be asked to submit your identifications again.

The Following are Acceptable Government-Issued Identifications Containing a Photograph and Signature:
• Current, non-expired driver’s license (or expired driver’s license and temporary permit)
• U.S. government-issued Military I.D.
• State-issued identification card
• Passport (US or foreign, current, non-expired)
• Current, non-expired federal-issued employment authorization document (EAD) photo identification card
• Alien registration card

PART 7: APPLICANT SIGNATURE

I certify that all the information provided in this application is true and complete. I understand that if the information I have provided in this application is found to be fraudulent, then my listing will be removed from the North Carolina Nurse Aide I Registry and I will be required to pass a North Carolina state-approved nurse aide I training program and the North Carolina state-approved nurse aide I competency examination. I give my permission to any state registry to disclose all information requested in this application to the North Carolina Division of Health Service Regulation, Health Care Personnel Education and Credentialing Section.

First Name (print): _______________________________  Last Name (print): _______________________________

Signature:  ___________________________________________  Date: _________________________________