Florida Certified Nursing Assistant Application Addendum

Additional Criminal History Questions Per Florida Statute 456.0635

Effective July 1, 2009

If testing at an In-Facility Site: Provide this completed form, along with all necessary documents to your training coordinator (do not send it directly to Prometric). Applications received without this document will be returned in bulk to the training program and will delay confirmation of test date(s).

If testing at a Regional Test Site: Mail this completed form, along with all necessary documents and the appropriate fees to: Prometric, Attn: Florida Nursing Assistant Program, 1260 Energy Lane, St. Paul, MN 55108. Applications received without this document will be returned to the applicant for completion and will delay confirmation of test date(s).

Candidate Information

(Print or type clearly and neatly. Incomplete or illegible forms will not be processed.)

(Print your name **EXACTLY** as it appears on your government-issued picture identification) Last Name	First Name	Middle Initial
Date of Birth (Month, Day, Year)	Email Address	
Daytime Phone Number (including area code) ( )	Evening Phone Number (including area code) ( )	

Social Security Number information is exempt from public records disclosure and not mandatory for testing (see Page 20 of the Candidate Information Bulletin). Retesters are required to enter their Prometric Unique ID. This number can be found on the Fail letter you received from your last test.

Social Security Number or Prometric Unique ID: ______________________________

Additional Criminal History Questions

These questions **MUST** be answered by the applicant.

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked.

Answer	Question
☐ Yes ☐ No	1a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If "No", do not answer 1b.)
☐ Yes ☐ No	1b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?
☐ Yes ☐ No	2a. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "No", do not answer 2b.)
☐ Yes ☐ No	2b. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?
☐ Yes ☐ No	3a. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the Federal Medicare program? (If "No", do not answer 3b and 3c.)
☐ Yes ☐ No	3b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?
☐ Yes ☐ No	3c. Did the termination occur at least 20 years prior to the date of this application?

Applicant Signature: ______________________________ Date: ______________

Florida Certified Nursing Assistant Application

If testing at a Facility: Provide this completed form, along with all necessary documents to your training coordinator (do not send it to Prometric).

If testing at a Regional Test Site: Mail this completed form, along with all necessary documents and the appropriate fees to: Prometric, Attn: Florida Nursing Assistant Testing Program, 1260 Energy Lane, St. Paul, MN 55108.

Candidate Information (Print or type clearly and neatly. Incomplete or illegible forms will not be processed.)

(Print your name as it appears on your identification) Last Name First Name Middle Initial		Date of Birth (Month, Day, Year) / /
Street Address (including Apt. number or P.O. Box*, if applicable)		
City State ZIP Code		
*If using a PO box as your mailing address, you must supply your physical address of legal residence as well.		
Daytime Phone Number (including area code) ( )	Cell Phone Number (optional). Including area code ( )	
Email Address (optional)	Race _ White _Black _Native American _Asian _ Mexican American _ Other Hispanic _ Puerto Rican _ Pacific Islander _ Other_________________	
Social Security Number information is exempt from public records disclosure and not mandatory for testing (see Page 20). Retesters are required to enter their Prometric Unique ID. This number can be found on the Fail letter you received from your last test. Social Security Number or Prometric Unique ID: ______________________________		
Do you have a High School diploma or equivalent? ☐ No ☐ Yes	Gender: ☐ Female ☐ Male	
Have you taken the CNA Written Exam or Skills Evaluation before? ☐ No ☐ Yes. If yes, when was the last time you took the exam: ___________ - ____________ - ____________		

Certification Option/Eligibility

(See explanation of certification options in this bulletin beginning on Page 2. Be sure to attach required documents.)

☑	Certification Training Route
	E1 - Completed a State-approved Nursing Assistant Training Program. (Complete the training info section below)
	E2 - Enrolled in a State-approved Nursing Assistant Training Program. (Complete the training info section below)
	E3 - Challenger. You have never been trained as a nursing assistant in Florida or any other state and have no nursing assistant experience.
	E4 - Other Nursing Training.
	E5 - Lapsed Nursing Assistant.

Training Information

(This section must be completed if the applicant has selected Training Route E1 or E2.)

Name of School or Facility	
Address of School or Facility	
Training/Proposed Completion Date: __ __/__ __/__ __	**Training Program Code**: __ __ __ __

Criminal History (Required)

☐ Yes* ☐ No	Have you EVER been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors, felonies, and juvenile offenses, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) is not a minor traffic offense for purposes of this question. *If you answered YES, please be prepared to create a typed or printed letter with arrest dates, city, state, charges and final dispositions and be prepared to send it to the Board Office upon request. (Do not send this information with your application for examination.)

Disciplinary History (Mandatory)

☐ Yes ☐ No	Have you ever been denied or is there now any proceeding to deny your application for any healthcare certification to practice in Florida or any other state, jurisdiction or country?
☐ Yes ☐ No	Have you ever had disciplinary action taken against your certification to practice any healthcare-related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
☐ Yes ☐ No	Have you ever surrendered a certification to practice any healthcare-related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
☐ Yes ☐ No	Do you have any disciplinary actions pending against your certification?

Residency (Mandatory)

Applicants must attest to the residency requirement for background screening pursuant to s. 464.203, F.S.

☐	I have been a resident of Florida continuously during the last five years. (Select FDLE Screening in chart below)
☐	I have not lived in Florida continuously during the last five years. (Select FBI Screening in chart below) Date moved to Florida: _____/_______/________.

Fingerprinting Note: Candidates who have lived in Florida less than five years must have electronic fingerprint scanning completed **after** submitting this application. See Page 6 of this Bulletin for more information on fingerprint scanning.

Test Site Information

Please check one of the following options for testing.

☐	**In-facility Testing:** My employer or training program is scheduling my testing and I will take the exam(s) at their location. (Facilities that have not previously tested with Prometric must go to www.prometric.com/NurseAide/FL or call 888.277.3500 for an In-Facility contract and request form.)	
☐	**Regional Test Site:** I am applying to test at a Regional Test Site. My preferred test site is indicated to the right. However, I understand that I will be assigned to the **first available** testing appointment in my area.	Test Site Code: _______________.

Testing/Retesting Fees

☑	**Exam (Check all that apply)**	**Fee**	**Total**
	Clinical Skills and Written (both in English)	$93	$
	Clinical Skills and Written Audio (both in English)	$97	$
	Clinical Skills (English) and Written (Spanish)	$93	$
	Clinical Skills (English) and Written Audio (Spanish)	$97	$
	Written (English)	$36	$
	Written Audio (English)	$40	$
	Written (Spanish)	$36	$
	Written Audio (Spanish)	$40	$
	Clinical Skills (English)	$57	$
☑	**Background Screening (Check only one)**	**Fee**	
	FDLE Screening (resided continuously in Florida during the last five years)	$34	$
	FBI Screening (resided in Florida less than five years)	$53.25	$
		Total Fee	**$**

Fees may be paid by cashier's check, company check, money order, MasterCard or Visa. Make checks payable to Prometric. **Personal checks and cash are not accepted. Fees are not refundable or transferrable.** To pay by **credit card**, complete the information below:

Card Type (Check One) ☐ MasterCard ☐ Visa	Card Number	Expiration Date
Name of Cardholder (Print)	Signature of Cardholder	

Applicant's Affidavit (must be completed by all applicants)

I certify that I am the applicant who is referred to in this application and that the statements herein are true. I understand that the results from my Competency Examination will be released to my nursing home employer or training program. I also understand that if any information given is not true and correct, my status as a certified nursing assistant may be jeopardized. I have read and understand the information in this Candidate Information Bulletin.

Applicant's Signature Date