Delaware Health and Social Services
Division of Health Care Quality, Office of Long Term Care Residents Protection
DELAWARE NURSE AIDE APPLICATION FOR RECIPROCITY

GENERAL INFORMATION AND INSTRUCTIONS (PAGE 1)

PART I: ELIGIBILITY - A nurse aide from another State may apply for certification to the Delaware Nurse Aide Registry in lieu of completing a State Approved Nurse Aide Training and Competency Evaluation Program by meeting the following qualifications:

1. Be listed on another State's Nurse Aide Registry as CURRENT or ACTIVE, and in good standing. You must have a Geriatric Nurse Aide (GNA) certification if coming from the State of Maryland.
2. Have no pending or substantiated findings of adult/child abuse, neglect, financial exploitation, and/or misappropriation of resident/patient property recorded on **any** State's Nurse Aide Registry.
3. Have work experience as a Certified Nurse Aide (CNA) [within the last 24-months] for at least three (3) months (full time) or at least 420 hours under the direct supervision of a Registered Nurse (RN) or Physician performing nursing related duties for pay. Nursing related duties include but are not limited to the following: bathing, dressing, grooming, toileting, ambulating, transferring, and feeding, observing and reporting the general well-being of the person(s) to whom a qualified person is providing care.
4. Have completed Nurse Aide Training at an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) with the number of hours at least equal to that required by the State of Delaware (150 total hours).

PART II: INSTRUCTIONS - The following is a detailed checklist of required items:

☐ 1. **Application for Reciprocity (Page 3/4)*:*** Must be completed by the applicant/CNA. **PLEASE PRINT LEGIBLY**. Please sign and date the bottom of the page verifying that the information provided is accurate. Please answer ALL questions. **Incomplete forms will be returned. Forms with white out will not be accepted.**

☐ 2. **Employer Verification Form (Page 5):** To be completed by a current or former employer (within the last 24 months). Verification of employment should include dates of employment, status (FT, PT, or Per Diem), job title, and the total number of hours worked during your tenure. Financial/Salary information is ***not*** required for this verification. Completed forms *must* be notarized. W-2's will not be accepted for employment verification. The Division reserves the right to randomly contact the Employer to verify the validity of submitted documentation. **Forms with white out will not be accepted.**

☐ 3. **Training Program Verification Form (Page 6):** To be completed by the Training Program Administrator. This verification form should be submitted if the applicant does not have work experience equal to 3-months (full time) or 420-hours. Training must have been completed in a Nurse Aide Training and Competency Evaluation Program (NATCEP) with a total number of hours equal to or greater than that required by the State of Delaware. The requirement for Delaware is 150 total hours (75-hours classroom/theory, 75-hours clinical) in a certified/skilled long-term care facility. The Division reserves the right to randomly contact the Training Program Administrator to verify the validity of submitted documents. **Forms with white out will not be accepted.**

☐ 4. Provide verification of current/active State Certification in good standing. Please list *ALL* States in which you have *ever* been certified whether currently active or inactive. You do not need to send verification from any State other than the State from which you are transferring.

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GENERAL INFORMATION AND INSTRUCTIONS (CONTINUED) (PAGE 2)

☐ 5. A *legible* copy of a Government issued Photo ID which shows your full [legal] name and your date of birth (preferably a State Driver License/Identification or a Passport). You do not need to send a copy of your social security card.

☐ 6. ***THE SEALED/UNOPENED COPY*** of the National Practitioner Data Base self query. Please visit https://www.npdb.hrsa.gov/ to request a search of your information; the cost is $4.00 for this self query. You will be required to submit payment using a credit/debit card. Once your request has been submitted, you will receive both an online response via email, and a sealed copy via US Mail. ***DO NOT OPEN THE ENVELOPE WHEN YOU RECEIVE IT***
This **sealed/unopened** copy should be submitted along with your application and other supporting documents. ****Applications will be returned if there is evidence of tampering or evidence that the envelope has been opened.**

☐ 7. The Reciprocity Processing fee is $30; please submit payment along with all other documents. Payment should be in the form of a check or money order, and made payable to: **STATE OF DELAWARE**. Please note that all fees made payable to the State of Delaware are non-refundable if your application is denied for any reason.

Mail Completed Application (Pages 3-6) Along With All Supporting Documentation and Payment To:

DHSS, Division of Health Care Quality
Office of Long Term Care Residents Protection
Attn: CNA Registry/Reciprocity
24 NW Front Street, Suite 100
Milford, Delaware 19963

If you have any questions, please call 302-424-8600 or 302-421-7410

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APPLICATION: TO BE COMPLETED BY NURSE AIDE (PAGE 3)

Instructions: Type or print (legibly). Your original signature is required; photocopies of this form will not be accepted. Forms with white out will not be accepted.

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____
Applicant's name should match name as it appears on the CNA Registry in your State. If different from Photo ID please provide documentation.
MAILING ADDRESS: _____CITY: _____

STATE: _____ ZIP CODE: _____ DAY TIME PHONE #:_____

EVENING PHONE #:_____EMAIL ADDRESS: _____

DATE OF BIRTH:____/____/____ GENDER: Male ____Female ____ LAST 4 DIGITS OF SSN: _____

HAVE YOU EVER BEEN CERTIFIED IN THE STATE OF DELAWARE? YES ___ NO ___
If YES, please provide Certification #: _____ (*Note: If your Delaware Certification lapsed within the past 24-months you may not be eligible for Reciprocity. Please contact our office.)

CURRENT STATE OF CERTIFICATION: ____ CERTIFICATION NUMBER:_____
(Must be GNA if from the State of Maryland) Please attach proof of current/active certification

Please list below *ALL* states in which you have *EVER* been certified whether currently active or inactive: _____ _____ _____ _____ _____ _____ _____ _____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS:

1) Is your current State certification in good standing (i.e. no pending or substantiated findings of adult/child abuse, neglect, financial exploitation and/or misappropriation of resident/patient property)? **Yes No**
   If NO, you may not be eligible for reciprocity. Please contact our office

2) Have you *EVER* had a negative finding entered against you on *ANY* State registry? **Yes No**
   If YES, give details on a separate sheet of paper.

3) Have you *EVER* been convicted of a criminal offense including any guilty pleas and/or no contest pleas? **Yes No**
   If YES, give details on a separate sheet of paper

4) Have you worked in a healthcare setting **within the last 24 months** as a CNA for at least three months or at least 420 hours [for pay] under the supervision of a Registered Nurse or Physician? **Yes No**
   If you answered YES to this question, please have Page 5 completed by your employer, and attach to this form. If you answered NO to this question, please answer question #5

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APPLICATION: TO BE COMPLETED BY NURSE AIDE (CONTINUED) (PAGE 4)

*If you answered YES to question #4 above, please check this box and skip question #5 ☐

5) If you have *NOT* worked for pay for at least three months full time and/or don't have at least 420 hours, have you completed a Nurse Aide Training and Competency Evaluation Program (NATCEP) of at least 150 hours? (75 hours classroom/theory, 75 hours clinical)
Yes No
If you answered YES to this question, please have Page 6 completed by your Training Program Administrator, and attach to this form. If you answered NO to this question, you may not be eligible for reciprocity. Please contact our office.

*I certify that all information provided in this application is true. I understand that my application may be denied for submitting false and/or fraudulent information. If approved, I understand that my Certification is subject to disciplinary action if findings later determine that I committed fraud, misrepresentation, and/or deceit in order to obtain the certification.

Signature of Applicant: _____ Date: _____

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EMPLOYER VERIFICATION FORM (PAGE 5)

Applicant's Name (As listed on Page 3): _____DOB: _____

1. **This form is to be completed by the *Employer***. Applicants, please enter *(only)* your name and date of birth above).
2. Forms must be notarized. If there is no licensed notary in the facility, Employers may submit verification on official company letterhead. Please remember that photocopies of this form will *NOT* be accepted. Forms with white-out will *NOT* be accepted.
3. Please Note: W-2s will *NOT* be accepted as proof of employment. Calls will not be made to *Work Net* or *The Work Number.*

EMPLOYER NAME: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____CONTACT NUMBER: _____

Please complete either Section 1 or Section 2 below:

Section 1

AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked FULL TIME from (mm/dd/yyyy)_____to (mm/dd/yyyy)_____ for pay, under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: _____ Signature: _____
Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____ County, In the State of ____.
Print Name: _____ (Place Notary Seal Here)
Signature: _____

OR…

Section 2

AS THE EMPLOYER, I certify that the individual named above is/was employed as a CNA and worked from (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ for pay, for a total of _____ hours under the supervision of a Registered Nurse or Physician. I am not aware of any disqualifying misconduct.

Print Name: _____ Signature: _____
Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____ County, In the State of ____.
Print Name: _____ (Place Notary Seal Here)
Signature: _____

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TRAINING PROGRAM ADMINISTRATOR VERIFICATION FORM (PAGE 6)

Applicant's Name (As listed on Page 3): _____DOB: _____

1. **This form is to be completed by the *NATCEP Administrator***. Applicants please enter *(only)* your name and date of birth above).
2. Forms must be notarized. If there is no licensed notary in the facility, Program Administrators may submit verification on official company letterhead. Please remember that photocopies of this form will *NOT* be accepted. Forms with white-out will *NOT* be accepted.
3. Please submit a copy of the Certificate of Completion attached to this form. Information documented on this form should match information on Certificate of Completion.

TRAINING PROGRAM NAME: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ZIP CODE: _____CONTACT NUMBER: _____

AS THE TRAINING PROGRAM ADMINISTRATOR, I certify that the individual named above completed a State Approved Nurse Aide Training and Competency Evaluation Program (NATCEP) on _____. The Program was a total of _____hours.

_____ Hours class/theory
_____ Hours clinical [in a certified/skilled long-term care facility]

Print Name: _____Signature: _____

Title: _____ Date: _____

Sworn and subscribed to me on this_____day of_____, 20____, in _____ County, In the State of _____.
Print Name: _____ (Place Notary Seal Here)
Signature: _____

*Please attach copy of Certificate of Completion to this form