PROMETRIC

Hawaii Nurse Aide Registry Recertification Form

This form is required to document and verify work experience so that you may renew your Hawaii Nurse Aide Certification. To renew your certification, you must have worked for pay performing nursing, nursing related services and/or direct patient care, under the supervision of a Licensed or registered nurse, for at least 8 hours during the last 24-month certification period. Forms should not be submitted more than 30 days before your current certification expiration period.

1. Name changes require that the nurse aide include a copy of the legal documents supporting the requested name change.
2. If you qualify for recertification, your new certification period will be for two years from expiration date.

Boxes below will be filled out by Prometric

Current Address Information:	Current Certificate Expires:	Current Certificate Number:

Instructions for the Nurse Aide:

1. Complete section 1 of this form
2. Take this form to your nurse aide employer to request that they complete section 2
3. If your work experience as a nurse aide occurred in a Medicaid/Medicare approved nursing facility and the employer completed section2, mail completed form to Prometric. No recertification fee is required.
4. If your work experience as a nurse aide occurred in a non-Medicaid/Medicare approved nursing facility but in a licensed/certified healthcare setting complete section 2 of this form, you must include your training completion certificate or be included in a letter from training program that you took and passed the 24 hour Competency Training course or 24 hours of Continuing Education Training. Mail to Prometric with the $27.00 renewal fee (cash and personal checks are not accepted). This fee is non-refundable.

Mail <u>COMPLETED</u> forms to: Prometric, Attn: HI Nurse Aide Program, 354 Uluniu Street, Suite 308, Kailua, HI 96734

Section 1 – Nurse Aide Information (must be filled out by Nurse Aide)

Last Name	First Name	Middle Name/Initial	Maiden Name (of applicable)
Street Address (including Apt. number or PO Box, if applicable)			Social Security Number
City	State		Zip Code
Home Phone Number (including area code)			Email Address

Please answer all the questions below by circling Yes or No. Any blank answers will result in your application being returned to you as incomplete. If you answer yes to any of the questions, please include an explanation on a separate piece of paper which includes date, place and nature of violation.

In the past 2 years, have you been convicted of a crime for which the conviction has **NOT** been annulled or expunged?	Yes	No
Has your Nurse Aide certification ever been revoked, suspended or otherwise subject to disciplinary action by another state registry?	Yes	No
Are you presently being investigated or is any disciplinary action pending against you?	Yes	No

Are you a (please check one) ☐ U.S. Citizen ☐ U.S. National ☐ Alien authorized to work in U.S.

Group 2 CNAs only must pay $27 for recertification. Fees may be paid by a 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 transferable.** 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	

I hereby certify that the statements, answers and representations made in this application and in the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of certification and is a misdemeanor (HRS, 710-1017 & Chapter 457A; & HAR, Chapter 89A). I further certify that I have read and will abide by the provisions of HRS, Chapter 457A and HAR, Chapter 89A.

_____ _____

Signature of Certified Nurse Aide Date

Section 2 – Please submit this form to your most recent Medicare/Medicaid Long-Term Care Nursing Facility or state DOH licensed/DHS certified health care setting. Your employer or past employer (within the last 24 months prior to your expiration date) must complete the following sections of this form and verify your work as a CNA.

Type of Employer:

☐ Group 1: Medicare/Medicaid Long-Term care Facility (do not submit recertification fees)

☐ Group 2: Licensed/Certified Health Care Setting (submit $27 recertification fee)

☐ Applicant has successfully completed and passed a 24hr competency evaluation course.

☐ Applicant has successfully completed 24 hours of Continuing Education and a skills competency review. Please include a copy of the certificate of completion with this application (group 2 only).

Name of Nursing Facility/Business		Facility/Business Phone Number (include area code)	
Facility or Business Address			
City	Island	State	Zip Code
Is your facility a Medicare/Medicaid Approved Facility? (check only one) ☐ Yes ☐ No		DOH/DHS/OHCA/HCBS #	
Nurse Aide's Date of Hire: Nurse Aide's last Date of Employment (if applicable):		Did the nurse aide work for your facility/business for a minimum of 8 hours providing nurse aide duties for pay working under the supervision of a licensed, practical, or registered nurse? ☐ Yes ☐ No	

Verification of employment must be signed by a Hawaii licensed health professional responsible for the development of the plan of care, HR Official, or state licensed/certified care setting employer. The CNA Recertification Form can be **self endorsed by a Group 2 state licensed/certified care giver** and must enclose a copy of current (foster or care home) state license/certificate and recertification fees with this form.

I hereby certify that the statements, answers and representations made in this application and in the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of certification and is a misdemeanor (HRS, 710-1017 & Chapter 457A; & HAR, Chapter 89A). I further certify that I have read and will abide by the provisions of HRS, Chapter 457A and HAR, Chapter 89A.

_____ _____

Print Name Title

_____ _____ _____

Signature Date Phone Number

This form was signed by a Hawaii licensed health professional as defined above, Employer's HR Official, or state licensed/certified care setting operator.