PLEASE Note: If you are seeking certification in Idaho via reciprocity from **MONTANA or IOWA** you must submit proof that you have completed an accredited CNA training course, along with this form.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID - BUREAU OF FACILITY STANDARDS
IDAHO NURSE AIDE PROGRAM
3232 W Elder Street
PO Box 83720
Boise ID 83720-0036

Phone: 800-748-2480
Fax: 208-334-6629

Print Form

VERIFICATION OF CURRENT NURSING ASSISTANT CERTIFICATION

MONTANA or IOWA -ONLY

Please type or print clearly using blue or black ink
Please complete the top of this form, sign, and sent to the Idaho Nurs e Aide Program

Applicant's Name _____
Last First Middle Maiden

Mailing Address: _____
Street Address City State Zip Code

Contact Phone Number - Home: _____ **Contact Phone Number - Work:** _____

☐ Unlisted Phone Number email _____

Identification Information SSN _____ **Date of Birth:** _____

Transferring from which State: ○ **MONTANA** ○ **IOWA** **Certification No.** _____

I authorize the release of my registry status and all relevant information requested below to the Idaho Department of Health and Welfare, Division of Medicaid, Bureau of Facility Standards.

Date: _____

_____
Signed By

Stop here! Do not write below this line. Mail this form to the Idaho Nurse Aide Program at the address above.

For Office Use Only

Other Names used by CNA: _____

CNA Obtained By: ☐ Deeming ☐ Endorsement ☐ Competency Exam

CNA Training - Date Completed: _____ **Competency Exam Date:** _____

Met OBRA Standards: ○ Yes ○ No **Certification Status Current:** ○ Yes ○ No

Original Date of CNA Certification _____

Disciplinary Status: ☐ None ☐ Probation ☐ Restricted ☐ Warning
☐ Suspension ☐ Denied ☐ Censure ☐ Revocation

Abuse: Are there any sustantiated findings of abuse? ○ Yes ○ No

Date Verified _____

_____
Signature/Title

(Spoke with _____ at _____ ___BON on _____, 2000__.)