CERTIFIED NURSE AIDE REGISTRATION RENEWAL APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59967 (R3-2015)

Online renewal is available and encouraged for all types of nurse aides and medication assistants. Please use the following web address: **http://www.ndhealth.gov/HF/North_Dakota_nurse_aide_registry.htm**
To print a CNA replacement card, please click on the following link: https://www.ndhealth.gov/hf/registry/print-certification-card.aspx

REGISTRANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name		Maiden/Middle Initial	M ☐ F ☐
Current Mailing Address (Include C/O Address)			County	
City	State	Zip Code	Social Security Number (Required)	
Date of Birth	E-Mail Address			
Home Phone	Work Phone		Cell Phone	
Registrant ID #		Current Expiration Date		

ALL QUESTIONS MUST BE COMPLETED BY REGISTRANT

1.	Have you ever been arrested, charged, or convicted of a felony (*You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action)* within the last two years?	☐ Yes	☐ No	
2.	Since you last renewed, or if this is your first renewal, has your registration been sanctioned or disciplined by any other jurisdiction?	☐ Yes	☐ No	
3.	Since you last renewed, or if this is your first renewal, have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	☐ Yes	☐ No	
4.	Since you last renewed, or if this is your first renewal, have you been investigated or are you presently being investigated by any other jurisdiction?	☐ Yes	☐ No	
5.	Since you last renewed, or if this is your first renewal, have you been denied registration or licensure by any other jurisdiction?	☐ Yes	☐ No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	☐ Yes	☐ No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	☐ Yes	☐ No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	☐ Yes	☐ No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. **Have you attached the appropriate documents?**	☐ Yes	☐ No	☐ NA

REGISTRATION CERTIFICATION

I certify the information provided is true, correct and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.	
Registrant Signature	Date

Employer to complete the back page.

OVER

EMPLOYERS, PLEASE COMPLETE THIS PAGE

INSTRUCTIONS:

- The registrant must have performed nursing or nursing related services for pay, under the direction of a licensed nurse. This page should be completed by a **NORTH DAKOTA EMPLOYER (out-of-state employer not accepted**).
- If the registrant is unemployed but has performed nursing or nursing related services for pay in North Dakota during the time they were certified, please complete the form below as a **PAST EMPLOYER (out-of-state employer not accepted).**
- There is **NO FEE** required for Certified Nurse Aide (CNA) renewal.
- Individuals who have **not** performed at least eight (8) hours of nursing or nursing related services for pay within their current registration period (previous 24 consecutive months) are NOT eligible for renewal and must complete a new competency evaluation process to obtain current registration as a CNA.

THE BOX BELOW MUST BE COMPLETED BY NORTH DAKOTA EMPLOYER ONLY

The registrant has *competently* performed a minimum of eight (8) hours of nursing or nursing related services for pay for the employer specified below.

Last date /shift worked in North Dakota during certification period (Cannot be later than expiration date)

(THE NEW EXPIRATION DATE WILL BE EXTENDED 2 YEARS FROM LAST DATE WORKED)

Employer Type: ☐ Long Term Care Facility ☐ Hospital ☐ Other (Specify)_____

Last Date Worked

Month	Day	Year

Name of Facility/Employer		**City**
Signature of Licensed Nurse	**Date**	**Phone Number**
My signature above indicates the information submitted is true, correct, and complete to the best of my knowledge.		**Employer E-mail**

Complete and return the entire form to:

North Dakota Department of Health
Division of Health Facilities
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov. Web site: http://www.ndhealth.gov/hf/