Nursing Assistant Registry Update Form

You are required by 42 CFR 483.156 to provide certain identifying information on this application such as certificate number, name, address, and telephone number. Your social security number will remain private. Your name and address are public information. The other identifying information, **except** for your social security number, will become public after you receive your certificate. If you do not supply adequate identifying information, you may not be eligible for placement on the registry.

PLEASE ALLOW 30 BUSINESS DAYS FOR PROCESSING

Instructions:

1. **Complete Section A** and **sign this form** at the bottom.
2. Have your **Employer** complete **Section B**.
3. **You must attach a copy of a recent paystub from the employer listed in Section B**. If you are not working in a nursing home or certified home health agency you will need to attach a copy of your job description from the employer listed in Section B.

Note: we will return your form unprocessed if the paystub and job description (if required) are not attached.

Section A: Applicant Information

Certificate Number:

Social Security Number (SSN):

Legal Name (Last, First, Middle - No initials):

Current Mailing Address (include apt):

City, State, Zip Code:

Phone Number
(include area code): _____

Email Address: _____

Name or SSN Change?

We will not process your name change unless you attach a photocopy of your marriage certificate, divorce decree or court order document. We will not process your social security number (SSN) change/correction unless you attach a photocopy of your social security card.

Section B: Employment Information

To be filled out by the employer.

Provide the following information about your ***past, present, or most recent employment*** **in Minnesota** as a nursing assistant. If you worked for a staffing agency, Section B must be filled out by the nursing facility where you worked. *This form cannot be completed by the staffing agency.*

Do not verify employment until after this individual has worked 8 hours independently for your agency/facility.

Name of Facility/Home Health Agency:

Facility/Agency Phone Number (include area code):

Current Address of Facility/Agency (including city):

Specify department/area this Nursing Assistant worked in:

Employment Start Date (Month/Day/Year): _____

Actual Last Working Date
(Month/Day/Year/Current): _____

~ Administrator or DON completes the following information ~

By signing this, you are verifying that this individual, **[circle one] is / was** working at the above-named nursing facility/agency **performing nursing assistant functions**, and the employment dates above are correct.

Signature (Admin. or Director of Nursing) Date

Signature (Nursing Assistant) Date

Minnesota Department of Health
Minnesota Nursing Assistant Registry
PO Box 64501
St. Paul, MN 55164-0501
health.FPC-NAR@state.mn.us | 651-215-8705

To obtain this information in a different format, call: 651-215-8705.