

APPLICATION FOR EXAMINATION

SECTION 3D. CURRENT STATE CERTIFICATION/PRACTICE

STATE	Type of Certification	ACTIVE/ NOT ACTIVE	CERTIFICATION NUMBER (if applicable)

SECTION 4. FEES AND SUPPORTING DOCUMENTS

- HOME HEALTH AIDE CERTIFICATION FEE: \$50.00

- CRIMINAL BACKGROUND CHECK: -To schedule your live scan fingerprints visit www.L1enrollment.com [now MorphoTrust] or call 1-877-783-4187. For questions contact the CBC unit at 202-442-9004. **Please Note: You must submit this application and obtain your certification number prior to registering for your fingerprint live scan. You can obtain your certification number at <http://app.hpla.doh.dc.gov/weblookup> 72 hours after your application has been submitted.**

- Your application along with all required supporting documents must be mailed from your school to the Board office. Schools: Please mail in a 9X12 inch envelope and do not staple or fold application.**

- Passport-Type Photos - Two recent and identical passport-type photos of the applicant’s face (approx. 2”X2”) with applicant’s name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.

- Copy of legal document supporting name change (if applicable). Acceptable documents are marriage certificate, divorce decree, court order or spouse’s death certificate.

- SSN Affidavit Form (if no SSN issued) This document can be found at www.hpla.doh.dc.gov

- HHA Training Program will provide your name, SSN, program start and completion dates on a list with your class;
OR

- Official Transcript in sealed envelope if completed LPN or RN Fundamentals course, OR

- CGFNS CES certificate if LPN or RN educated in foreign country

- Provide a detailed explanation if you answer “Yes” to any of the questions in Section 5 (on next page). Submit copies of personnel action (e.g. termination due to unsafe practice) actions taken against your license/certification or other relevant documents.

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SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your Certification** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be certified if you have failed to file your District tax returns. IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Information presented above is in compliance with the requirement to submit with your application for licensure under

A.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to safely provide patient care?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
B.	Do you have a mental condition that currently impairs your ability to safely provide patient care?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	Have you ever been arrested, or pled guilty instead of going to trial, or been found guilty after a trial, or pled nolo contendere, regardless of whether the arrest, conviction or plea of nolo contendere was sealed or expunged?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	Please answer with respect to DC or any other jurisdiction/state: (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license/certification after formal charges have been filed against you or while under investigation? (2) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION 6. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE

PRINT NAME

DATE

PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.