

New York Nurse Aide Application





Note: Before you enter your name below, check the government issued identification that you will use for admission to testing. If the name you use below does not match the name on the identification you provide on the day of testing, you will not be allowed to take your exam.

Instructions:

- To apply online please go to: www.prometric.com/NurseAide/NY
- Mail the completed form to Prometric, Incomplete or illegible forms will not be processed.

I am applying for ADA Accommodations. I understand that not all accommodations can be approved

• If applying for ADA Accommodations please fill out the box below and go to www.prometric.com/nurseaide to print the ADA Accommodations Request Packet.

and must be requested 30 days in advance of a test date. Included with this application is the ADA request packet. Candidates applying to take just an Oral Exam do not need to apply for ADA accommodations; this offering is available to all candidates.						
□ No □ Yes						
Section 1. Candidate Information: MUST be completed by all applicants.						
Social Security Number (mandatory)(print one digit First Name (print one letter in each box):	in each box)					
Middle Initial (print in box):						
Last Name (print one letter in each box): Street Address (including Apt if applicable. You must so	upply your physical address of legal residence)					
City Date of Birth (Month, Day, Year)	State ZIP Code Daytime Phone Number (including area code)					
Ethnic Group (Optional) (Check only one box) American Indian or Alaskan Native Asian American/Pacific Islander Black/African American Mexican American Other Hispanic or Latin American White Other	Education Level (Check the box next to your highest education level completed. Check only one box.) 4th grade or less Between 5th and 8th grades Some High School, did not graduate High School diploma or GED Trade or Technical School Certificate One or two years college, no degree Two-year college degree More than two years college, no degree Four-year college degree or more					
Gender: ☐ Female ☐ Male	Email Address (this is a mandatory field – application will not be processed without an email address):					
Maiden name(if applicable):						

County in which you live:		Current Nursing Home Employment Status: Full Time Part Time Not Employed (If you are currently working in a nursing home, have your Employer complete Section 2 of this application)						
Do you currently hold a certification as a nurse aide or are you listed on the nurse other than New York? If yes, list all the states below and indicate if you are in go Registry in that state. Good standing means that you have no findings or convict neglect or misappropriation of resident belongings. Add an additional sheet of pa required.				urse aide good sta victions of	registry in any state nding on the resident abuse,	Yes	□No	
Issuing State	Good standing?	Issuing State	Good stand	ling?	Issuing State	Good star	nding?	
	☐ Yes ☐ No		☐ Yes	☐ No		☐ Yes	☐ No	
☑ Certification	Route (Check only	one. See further exp	lanation of r	outes in t	his handbook beginni	ng on Page	2)	
Route 1. New		One. See farther exp	idilation or i	outes iii t	riis ridridbook begiirii	ng on rage	, 2.)	
Route 2. Reci	procity/CNA From An	other State						
Route 3. Grad	luate Nurses							
Route 4. RNs	and LPNs licensed in	the U.S.: Enter RN/L	PN License	Number:				
	ign-Trained Nurses							
	·	er NYS Nurse Aide Ce /S Nurse Aide Certific						
		your highest educati			theck only one box.)			
4th grade or l	ess	- yg		.,				
	and 8th grades							
	:hool, did not gradı iploma or GED	ıate						
	nical School Certifi	cate						
One or two ye	ears college, no deg	gree						
Two-year colle								
	o years college, no ege degree or mor							
□ Four-year con	ege degree or mor	е						
Section 2. MUS	T be completed	by your emplo	ver.					
(This section must be	Section 2. MUST be completed by your employer. (This section must be completed by your employer if you are employed in NYS by a Health Care Provider with a Nurse Aide Employer Facility Code.)							
Employer Facility Cod	de Number:			Date of I	Hire: (MONTH/DAY/	YEAR)		
33 🗆 🗆 []/□□/□			
What Type of Nurse	Aide Employer is the F	acility? Nursing	Home [7 Home	Health Agency	Hospi	tal	
What Type of Naise	What Type of Nurse Aide Employer is the Facility? ☐ Nursing Home ☐ Home Health Agency ☐ Other:							
Name of Facility or Agency Where Employed								
Address of Employer								
City		S	tate 🔲 🗆	ZIF	o Code			
Employer's Signature	9			Date				
Section 3. MUST be completed by the training program coordinator.								
(This section must be completed by the training program coordinator.								
Training Program Co	de Number:			ected Pro DNTH/DAY	gram Completion Date /YEAR)	<u>;</u>		
3367	1 1 2							
Name of Nurse Aide International De	Training Program evelopment Institu	ite						

Trai							
P.	ning Program Mailing Address O. BOX 20260						
	[X] [X]		1				
City	New York, State N Y ZIP Code	1 0 0 0	1				
	s exam taker has successfully completed a state-approved Nurse Aide ning Program. Training Program Coordinator/Instructor Signature						
De	empsey Raines						
	am Site Information (Check one of the following options.)						
X	In-facility Site: My employer or training program is scheduling my exams and I will take the exams at their facility. I will give this application form to the facility coordinator (do not send it to Prometric).						
	Regional Test Site: I am applying to take my exams at a Regional Exam Site. I will receive an admission letter with my specific exam date, time and location. For a list of sites please go to www.prometric.com/nurseaide/ny						
Tes	st Site Code:						
Sec	ction 4. Fees.						
	Exam Title	Exam Fee		Total			
Cli	nical Skills AND Written exams (first-time tester)	\$115	\$	115.00			
Cli	nical Skills AND Oral exams (must have ADA paperwork)	\$115	\$				
	nical Skills AND Oral exams	\$135	\$				
Cli	nical Skills Retest (Prometric ID number)	\$68	\$				
Wr	itten Retest (Prometric ID number)	\$57	\$				
Or	al Retest (Prometric ID number)	\$67	\$				
	Additional Services	Fee					
Re	ciprocity/CNA From Another State and NYS RNs and LPNs Application Processing	\$50					
	ciprocity/cita from Another State and 1113 Kits and El 113 Application Frocessing	\$50	\$				
Pay	ment: Fee(s) may be paid by money order or certified check made payable to "NY Comr A." Your name and ID (if available) must be written on the form of payment. Personal c	Total missioner of Health	\$	115.00			
Payı NYN. not	ment: Fee(s) may be paid by money order or certified check made payable to "NY Comr	Total missioner of Health hecks and cash	\$	115.00			
Payi NYN. not	ment: Fee(s) may be paid by money order or certified check made payable to "NY Comr A." Your name and ID (if available) must be written on the form of payment. Personal caccepted. Fees are nonrefundable. ction 5. Applicant's Affidavit: MUST be completed by all applican Agreement of Authorization, Confidentiality, and Release Statement	Total missioner of Health hecks and cash ts.	\$ n, are				
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Payer NYN, not 1 2	ment: Fee(s) may be paid by money order or certified check made payable to "NY Comr A." Your name and ID (if available) must be written on the form of payment. Personal caccepted. Fees are nonrefundable. Etion 5. Applicant's Affidavit: MUST be completed by all applican Agreement of Authorization, Confidentiality, and Release Statement I agree that the New York State Division of Residential Care and Service may investigate the sunderstand that exam results will be sent to my approved training program and/or emplot (when applicable). I understand that if I have given false information in this application, my nurse aide certification of the prosecuted by New York State. Further, I understand that if I cheat or engage in the exam I may be disqualified from continuing to take the exam or my exam results may I understand that a record of the successful completion of this competency evaluation and	Total missioner of Health hecks and cash ts. ne information in th hying nursing home exation may be inval to other prohibited be be invalidated. information from a Registry.	\$ idate ehav	pplication. d and ior during			
Payer NYN not Sec 1 2 3	ment: Fee(s) may be paid by money order or certified check made payable to "NY Comr A." Your name and ID (if available) must be written on the form of payment. Personal caccepted. Fees are nonrefundable. ction 5. Applicant's Affidavit: MUST be completed by all applican Agreement of Authorization, Confidentiality, and Release Statement I agree that the New York State Division of Residential Care and Service may investigate the I understand that exam results will be sent to my approved training program and/or emplot (when applicable). I understand that if I have given false information in this application, my nurse aide certifical could be prosecuted by New York State. Further, I understand that if I cheat or engage in the exam I may be disqualified from continuing to take the exam or my exam results may I understand that a record of the successful completion of this competency evaluation and on this form will be included in my record in the New York State Nursing Home Nurse Aide	Total missioner of Health hecks and cash at ts. The information in the sying nursing home attion may be invalidated be invalidated. Information from a Registry. The information from a Registry.	sidate sehav and cc t have that Pron	pplication. d and ior during ontained ook. e any at I am netric, the			

Mail to: Prometric, ATTN: NY Nurse Aide Program, 7941 Corporate Drive, Nottingham, MD 21236.

Signature of Candidate

Date: _____



Candidate Name:						
Application Payment						
Certified Check or Money Order Payments						
☐ Certified Check	☑ 3 rd Party/Facility Check	☐ Money Order				
Certified Check/Money Order/3 rd Party/Facility Check Number (one number or letter in each box):						

Payment: Fee(s) may be paid by money order or certified check made payable to "NY Commissioner of Health, NYNA." Your name and ID (if available) must be written on the form of payment. **Personal checks and cash are not accepted. Fees are nonrefundable.**