



Washington State Department of  
**Health**  
 Nursing Assistant Program  
 P.O. Box 47877  
 Olympia, WA 98504-7877  
 360.236.4700

## **Nursing Assistant Registered Application Packet**

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### **Important Social Security Number Information:**

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

#### **Mail your application with Initial documentation and your check or money order payable to:**

Department of Health  
 PO Box 1099  
 Olympia, WA 98507-1099

#### **Send other documents not sent with initial application to:**

Nursing Assistant Program  
 PO Box 47877  
 Olympia, WA 98504-7877

#### **Contact us:**

360.236.4700

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Nursing Assistant Program  
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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the [fee page](#) for current fees.

**#1: Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

**Legal Name:** List your full name.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the city, state and country where you were born.

**Address:** List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.

See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**#2: Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

- #3: Other License, Certification, or Registration:**  
List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.
- #4: AIDS Education and Training Attestation:**  
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patient care, courses, or formal training required by [WAC 246-12-260](#). Course content can be found in [WAC 246-12-270](#).
- #5: Applicant's Attestation:**  
You must sign and date this for us to process the application. Read this very carefully.



Nursing Assistant Program  
 P.O. Box 1099  
 Olympia, WA 98507-1099  
 360.236.4700

Background  
 Check  
 Stamp  
 Here

Date  
 Stamp  
 Here

Revenue 029903000

## Nursing Assistant Registered Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you read the instructions.

### 1. Demographic Information

**Social Security Number** (If you do not have a social security number, see instructions.)

Male  
 Female

Name                      First                                      Middle                                      Last

Birth date (mm/dd/yyyy)

Place of birth

City                                      State                                      Country

Address

City                                      State                                      Zip                                      County

Country

Phone (                      )                      Fax (                      )                      Cell (                      )

Email address

Mailing address (if different from above)

City                                      State                                      Zip                                      County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)?  Yes  No    If yes, list name(s):

Will documents be received in another name?  Yes  No

If yes, list name(s):

#### For Office Use Only

Issuance Date \_\_\_\_\_ License # \_\_\_\_\_

Validation Date \_\_\_\_\_ Received \_\_\_\_\_

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .....

**Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

- b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .....

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
- b. Diverted controlled substances or legend drugs? .....
- c. Violated any drug law? .....
- d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....

## 3. Other License, Certification, or Registration

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. If you need more space, attach a piece of paper.

State/Jurisdiction	License Type	License Number	License		Method Licensed
			Issue Date	Expiration Date	

## 4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission, and treatment of AIDS. The education was through my professional education or through the completion of DSHS required training for caregivers or staff employed in DDD Certified Residential Programs. This includes the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my certification or registration may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

## 5. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of Washington the following is true and correct:  
(Print applicant name clearly)

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ in \_\_\_\_\_ (city, state)  
mm/dd/yyyy

By: \_\_\_\_\_  
Signature of applicant



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## License / Certification / Registration Verification

### PART 1: Note to applicant

Complete part 1 Submit form(s) to all state nursing assistant commissions/boards/committees where you have ever been licensed, certified, or registered.

Name \_\_\_\_\_

I was licensed/certified/registered by the \_\_\_\_\_ State \_\_\_\_\_ Commission/Board/Committee of nursing assistant under the name \_\_\_\_\_

My original license/certification/registration number is \_\_\_\_\_

My Address is \_\_\_\_\_

Signature of applicant \_\_\_\_\_

### PART 2

To be completed by the state nursing assistant commission/board/committee and returned to the Washington State Department of Health at the address provided above.

License/Certification/Registration issued on \_\_\_\_\_ Number \_\_\_\_\_

Applicant licensed by: Exam \_\_\_\_\_ Endorsement \_\_\_\_\_ Waiver \_\_\_\_\_

Status of License/Certification/Registration:  Current  Not Current If not, explain \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Has license/certification/registration ever been encumbered in any way? (Revoked, suspended, surrendered, restricted, placed on probationary status or under investigation.)  Yes  No If yes, explain \_\_\_\_\_



Signature \_\_\_\_\_

Name/Title \_\_\_\_\_

State \_\_\_\_\_

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## **Health Professions Reference Numbers and Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#"><u>UDA RCW 18.130</u></a>
Administrative Procedure Act .....	<a href="#"><u>APA RCW 34.05</u></a>
Administrative procedures and requirements .....	<a href="#"><u>WAC 246-12</u></a>
Nursing Assistance Law .....	<a href="#"><u>RCW 18.88</u></a>
Nursing Assistance Rules.....	<a href="#"><u>WAC 246-841</u></a>

### **Online**

AIDS Training .....	<a href="#"><u>Reference Page</u></a>
Nursing Assistant Program.....	<a href="#"><u>Web page</u></a>