NURSE AIDE & MEDICATION I RENEWAL APPLICATION

North Dakota Department of Health
Division of Health Facilities
SFN 59965 (R2-2012)

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

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		
Name of Employer			City	State	
Employer's Contact Name			Employer's Phone Number		
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 or nursing license 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.	
Applicant Signature	Date

FOR STATE USE ONLY Date Received: _________ Amount Received: $______ Cash MO or CK#__________

THE FOLLOWING IS TO BE COMPLETED BY A LICENSED NURSE OR EMPLOYER

VERIFICATION OF COMPETENCE

For each area, the licensed nurse or employer verifies that the nurse aide has demonstrated competencies in the following areas. **Signature of Employer** ________________________ **Date** _____________ **OR** **Signature of Licensed Nurse** ___________________ **Date** _____________ **AND** **ND Nurse License Number** ______________________________________	Date of satisfactory competency verification **(within the last year)** **MM/DD/YYYY**	Comments
1. Infection control.		
2. Safety and emergency procedures.		
3. Collection and documentation of basic objective and subjective client data.		
4. Activities of daily living (applicable to setting).		
5. Decision-making skills.		
6. Client rights.		
7. Communication and interpersonal skills.		
8. Client cognitive abilities and age specific needs.		

REGISTRANT EMPLOYMENT INFORMATION

Employment Status ☐ Employed ☐ Not-Employed	Date of Hire as a Nursing Assistant **(MM/DD/YYYY)**

EMPLOYER INFORMATION AND SIGNATURE

Employer (If applicable)		Phone Number	
Address	City	State	Zip Code
Employer or Licensed Nurse Signature		Date	

Medication Assistant Competency Verification

The section below must be completed by a licensed or registered nurse.

This Medication Assistant I has completed the necessary competency verification within the past year, as indicated by NDAC 33-43-01-14. I certify the competency of this Medication Assistant I by my signature below.

Signature	Date
Licensed Nurse or Registered Nurse Number	Expiration Date

Please remit $50 (U.S. dollars) Non-refundable Fee
($25.00 for Nurse Aide Renewal and $25 for Medical Assistant I Renewal)

Make checks and/or money orders payable to the North Dakota Department of Health.
All completed forms and checks or money orders must be sent or delivered together to:

North Dakota Department of Health
Division of Accounting
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