

a. <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation ended for the conviction or plea?
b. <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" to 2, were you arrested or charged for the felony before July 1, 2009?
*3. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been terminated for cause from the Florida Medicaid Program under Section 409.913, Florida Statutes? (If you responded "No" to question 3, skip to question 4.)
a. <input type="checkbox"/> Yes <input type="checkbox"/> No	If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the past 5 years?
*4. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? (If you responded "No" to question 4, skip to question 5.)
a. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been in good standing with a state Medicaid program for the past 5 years?
b. <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the termination occur at least 20 years before the date of this application?
*5. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

***Disciplinary History (Mandatory)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied or is there now any proceeding to deny your application for any healthcare certification to practice in Florida or any other state, jurisdiction or country?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had disciplinary action taken against your certification to practice any healthcare-related profession by the licensing authority in Florida or in any other state, jurisdiction or country?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever surrendered a certification to practice any healthcare-related profession in Florida or in any other state, jurisdiction or country while any such disciplinary charges were pending against you?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any disciplinary actions pending against your certification?

***Criminal History (Mandatory)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you EVER been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for the purposes of this question. If you answered YES, please be prepared to create a typed or printed letter with arrest dates, city, state, charges and final dispositions and be prepared to send it to the Board Office upon request. (Do not send this information with your application for examination.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you EVER had any records sealed pursuant to section 943.059, F.S., or any other states applicable statute
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you EVER been adjudicated delinquent or have had adjudication of delinquency withheld?

***Health History (Mandatory)**

If you answer "Yes" to any of the questions in this section, all supporting documentation should be sent to the Florida Department of Health.

1. <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?
2. <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?
<p>If you answered "Yes" to any of the questions in this section, you are required to send the following items:</p> <ul style="list-style-type: none"> • Please provide a letter from a licensed health practitioner, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety, and stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied. • <u>Self Explanation</u>, explaining the medical condition(s) or occurrence(s) and current status. 	

***Social Security Number**

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Pursuant to 466(a)(13), 42 U.S.C. §666(a)(13), the department is required and authorized to collect Social Security Numbers relating to applications for professional licensure. Additionally, section 456.013(1)(a), Florida Statutes, authorizes the collection of Social Security Numbers as part of the general licensing provisions. This information is exempt from public records disclosure.

Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L.Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

*Certification Option/Eligibility

Please check a certification route.

<input checked="" type="checkbox"/>	Certification Training Route
	E1 - Completed a State-approved Nursing Assistant Training Program. (Complete Training Info section below).
	E2 - Enrolled in a State-approved Nursing Assistant Training Program. (Complete Training Info section below).
	E3 - Challenger. You have never trained as a nursing assistant and have no nursing assistant experience.
	E4 - Other Nursing Training.
	E5 - Lapsed Nursing Assistant.

Training Information

This section must be completed if the applicant has selected Training Route E1 or E2.

*Training Completion Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		*Training Program Code (if available – see completion certificate)	
*Name of School or Facility			
*Address of School or Facility (Street Address or P.O. Box)			
City		State	<input type="text"/> <input type="text"/>
		ZIP Code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

*Test Site Information

Please check one of the following options.

<input checked="" type="checkbox"/>	Test Site
	Testing at your Facility: My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator. Do not send to Prometric.
	Regional Test Site: I am applying to test at a Regional Test Site. My preferred test site code is listed. <i>A current list of Test Sites with codes can be found online at www.prometric.com/NurseAide/FL.</i>
	*Test Site Code:

Exam Selection and Processing/Exam Fees

- **Acceptable Forms of Fee(s) Payment:** certified check, money order, MasterCard, Visa or American Express. Make certified checks payable to Prometric. **Personal checks** and **cash** are **not** accepted. Fees are **non-refundable and non-transferrable**.
- The **Payment Form** (last page) **must** be submitted with this application **regardless of payment type**.

<input checked="" type="checkbox"/>	Exam (Check all that apply)	Fee	Total
	Clinical Skills and Written (both in English)	\$155	\$
	Clinical Skills and Written Oral(both in English)	\$155	\$
	Written (English)	\$35	\$
	Written Oral (English)	\$35	\$
	Clinical Skills (English)	\$120	\$
	Clinical Skills (English) and Written (Spanish)	\$155	\$
	Clinical Skills (English) and Written Oral (Spanish)	\$155	\$
	Written (Spanish)	\$35	\$
	Written Oral(Spanish)	\$35	\$
	Total Fee	\$	\$

An additional rescheduling/no show fee of \$25 is required to reschedule an exam appointment with less than five business days notice, no-shows, late arrivals, or not allowed to test. Reschedule fees may apply to roster changes made by IFT testing locations.

***Applicant's Affidavit and Candidate Release Statement**

***Electronic Fingerprints**

Please review the Florida Department of Law Enforcement statement and the Federal Bureau of Investigation document located in the 'Forms' section of the Candidate Bulletin.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation. (Located in the Candidate Bulletin available online).

Yes No

***Candidate Attestation**

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand if information given is not true, my registration status as a nursing assistant may be at risk.
- I understand if I pass both parts of the Nursing Assistant Competency Exam, I will be placed on the Registry.
- I understand I may be asked to play the part of the resident for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the FLDOH, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand all information required on the registration application may be made available for public disclosure (except for the Social Security Number).

***Candidate Signature (in box below)**

Date: _____

If you **DO NOT** receive your emailed ATT letter from Prometric within **10-14 business days** of receipt at Prometric, please contact Prometric.

Questions: For additional information, please visit our website at www.prometric.com/nurseaide.

Please make a copy of all completed forms for your personal records.



Payment Form

*Candidate Name: _____

*Date of Birth: _____



Note: You have the option of submitting your application and payment online using your credit card at www.prometric.com/en-us/clients/nurseaide.

Credit Card Type (Check One)

MasterCard Visa American Express

Card Number	Expiration Date □ □ / □ □
Amount \$ ____ . ____	C/C Security Code □ □ □ □
Name of Cardholder (Print)	
Signature of Cardholder	

Certified Check or Money Order Payments

Certified Check 3rd Party/Facility Check Money Order

Certified Check/Money Order/3 rd Party/Facility Check Number (one number or letter in each box):
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

Please mail completed forms to:

Prometric
ATTN: FL Nurse Aide Program
7941 Corporate Drive
Nottingham, MD 21236.