

# UTAH NURSING ASSISTANT REGISTRY

550 East 300 South

Kaysville, Utah 84037

Phone: (801) 547-9947

## NURSING ASSISTANT APPLICATION FOR CERTIFICATION TESTING

NAME (PLEASE PRINT) \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ NAME OF HIGH SCHOOL \_\_\_\_\_

### CONSENT TO RELEASE OF INFORMATION

I understand that upon successful completion of the nurse aide training and competency evaluation program, my name, address, date of birth, social security number, and name and date of state-approved training and competency evaluation program will be entered into the nurse aide registry.

I understand that each allegation of resident neglect, abuse or misappropriation of residents' property against a nurse aide will be thoroughly investigated by the Division of Health Care Financing before any name is reported to the registry. The Division of Health Care Financing shall ensure that a reasonable opportunity for a hearing has been offered to the nurse aide, and will show the hearing has either taken place or the nurse aide has waived his/her rights to a hearing.

I understand that any substantiated allegation, along with a statement submitted by the nurse aide disputing the findings, or, if applicable, any statement by the individual waiving his/her rights to a hearing, will also be entered into the registry. I understand that by law this information must be available to the public.

I understand that an individual who has not performed nursing or nursing-related services for a continuous 24-month period for pay after completion of a training and competency evaluation program must complete a new training and/or competency evaluation program.

I understand that if I am employed by a Medicare/Medicaid certified nursing facility, the nursing facility where I am employed is responsible to pay for the training, course materials, and competency evaluation (OBRA 1989, Section 6901).

I certify that the information given above is true and accurate.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that the above signed has successfully completed the nursing assistant training and competency evaluation provided at this institution.

Instructor Signature \_\_\_\_\_ Teaching Institution \_\_\_\_\_ Completion Date \_\_\_\_\_

**Please make certified check or money order payable to UNAR**

**No cash or personal checks. If paying with credit card complete information below**

**The UNAR only accepts applications by mail**

**\*\*Credit Card \_\_\_\_\_ # \_\_\_\_\_ Expiration date \_\_\_\_\_**

**Visa/Mastercard/Discover only – Signature \_\_\_\_\_**

Test Choices (please mark)			Cost
Written 1 _____	Retest 2 _____	Retest 3 _____	\$35
Skills 1 _____	Retest 2 _____	Retest 3 _____	\$35

Amount Enclosed \$ \_\_\_\_\_

**ALL TESTING CANDIDATES:** Sample examination questions, a practice exam, skills protocol and examples of skills that you will be tested on are provided in the Candidate Handbook on line at

[www.utahcna.com](http://www.utahcna.com).

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