

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 check or money order payable to UNAR
The UNAR does not accept credit cards
The UNAR only accepts applications by mail

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.

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