

UTAH NURSING ASSISTANT REGISTRY

550 East 300 South
Kaysville, Utah 84037

Phone: (801) 547-9947

NURSING ASSISTANT APPLICATION FOR CERTIFICATION TESTING

NAME (PLEASE PRINT) _____

SOCIAL SECURITY # _____ BIRTHDATE _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

CURRENT HIGH SCHOOL STUDENT Y / N SCHOOL NAME _____

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 nurse aide training program provided at this institution.

Instructor Signature

Teaching Institution

Completion Date

Please make checks payable to UNAR

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

Last Update 08/06