UTAH NURSING ASSISTANT REGISTRY
550 East 300 South
Kaysville, Utah 84037
Phone: (801) 547-9947

APPLICATION FOR CERTIFICATION BY RECIPROCITY

Please complete the information requested below. Send this form to the Utah Registry at the address above with $10 fee. **No cash or personal checks**. Make certified check or money order payable to UNAR.

NAME:_____
Last First Middle Maiden

PRESENT ADDRESS: _____PHONE #_____

CITY_____ STATE_____ ZIP_____

SOCIAL SECURITY #_____ BIRTHDATE_____

CERTIFICATE #_____ ISSUE DATE _____

State(s) certified as nursing assistant _____

CONSENT TO RELEASE 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).

SIGNATURE_____DATE_____

My signature serves as authorization to verify certification from the State(s) Registries listed.
I certify that the information given above is true and accurate.

10/10