Reset Form

NURSE AIDE COMPETENCY EVALUATION APPLICATION

State Form 43731 (R8 / 7-21)
INDIANA DEPARTMENT OF HEALTH-DIVISION OF LONG TERM CARE

* This agency is requesting disclosure of your Social Security Number in accordance with 42 CFR 483.156(c)(1)(ii); disclosure is mandatory and this application cannot be processed without it.

SECTION I - APPLICANT INFORMATION

Name of applicant			Social Security Number *
Address *(number and street)*	City	State	ZIP code + 4
Telephone number ( )	E-mail address		County
Date of birth *(month, day, year)*	Date of hire *(month, day, year)*	QMA number	

SECTION II - COURSE INFORMATION (THIRTY (30) HOUR CLASSROOM EDUCATION)

Name of facility / school			Facility number	
Address *(number and street)*	City	State	ZIP code + 4	County
Telephone number ( )	E-mail address		Date of classroom completion *(month, day, year)*	

I verify that the above named applicant has successfully completed at least thirty (30) hours of classroom instruction utilizing the Indiana Department of Health (IDOH) approved standards and resident care procedures and that a summary of all assessment tools and the RCP checklist are completed and available in this applicant's file.

Signature of program director	Date *(month, day, year)*
Printed name of program director	

SECTION III - COURSE INFORMATION (SEVENTY-FIVE (75) HOUR CLINICAL EDUCATION)

Name of facility			Facility number	
Address *(number and street)*	City	State	ZIP code + 4	County
Telephone number ( )	E-mail address		Date of clinical completion *(month, day, year)*	

I verify that the above named applicant has successfully completed at least seventy-five (75) hours of clinical experience supervised by a licensed nurse utilizing Indiana Department of Health (IDOH) approved resident care procedures and that a summary of the RCP checklist are completed and available in this applicant's file.

Signature of clinical supervisor	Date *(month, day, year)*
Printed name of clinical supervisor	

APPLICANT VERIFICATION

I verify that the above information is correct.

Signature of applicant	Date *(month, day, year)*

SECTION IV - APPLICANT'S TEST STATUS

- ☐ Completed Indiana 105 hour Training
- ☐ Transferring From SLO
- ☐ Psychiatric Attendant
- ☐ Out of State CNA Verification
  Name of state: _____
- ☐ Foreign Nurse
  Country: _____
- ☐ Student Nurse *(currently enrolled nursing student)*
  School: _____
- ☐ Graduate Nurse
  Waiting to: ☐ Take Boards ☐ Retake Boards
- ☐ Other: _____
  _____

SECTION V – TEST / MONITOR INFORMATION

TEST NUMBER 1

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail

TEST NUMBER 2

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail

TEST NUMBER 3

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail