



New York Certified Nursing Assistant Examination Application

Instructions:

- Please go to: www.prometric.com/NurseAide/NY to print the current version of this application and all other forms. DO NOT submit photocopies as this may impact the ability to process the application.
- Incomplete, blurred or illegible forms will not be processed.
- To apply online please go to: www.prometric.com/NurseAide/NY
- All submitted applications must include the Payment Form at the end of the application.
- Please mail completed original forms to Prometric, ATTN: NY Nurse Aide Program, **6211 Greenleigh Avenue, Suite 400, Middle River, MD 21220**



The name you provide on this application must match EXACTLY the name on your government-issued identification you will provide on the day of testing. If the name does not match EXACTLY, you will not be permitted to take your exam and will forfeit any test fees.

If you have previously taken a nurse aide exam with Prometric and your legal name has changed since then, you must provide a copy of acceptable legal documentation along with this application. Acceptable documents include marriage certificate; divorce decree; birth certificate; and legal name change court documents. Prometric will be unable to process your application until the legal acceptable documents are received.

- If applying for Testing Accommodations under the Americans with Disabilities Act (ADA):
 - Please go to to www.prometric.com/nurseaide to print the required ADA Accommodations Request Packet. This packet MUST be completed and submitted with this application.
 - Fill out the box below.

Note: Candidates applying to take the Oral (audio) Exam do not need to apply for ADA accommodations.

I am applying for Americans with Disabilities Act (ADA) accommodations. I am requesting testing accommodations and have included the required ADA Accommodations Request Packet along with this application. I understand I must request accommodations 30 days in advance of the test date and not all accommodations can be approved.

Yes No

Candidate Information

All fields marked with * are required. Print one number/letter in each box where required.

*Have you taken a Certified Nurse Aide exam with Prometric? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*First Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Middle Initial <input type="text"/>
*Last Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*Date of Birth (Month/Day/Year) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Previous name (if applicable): <input type="text"/>

*Street Address (including Apt. number or P.O. Box, if applicable)					
*City		*State		*ZIP Code	
		<input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*County (first four letters only)			* Phone Number (including area code)		
			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
*Email Address (application will not be processed without an email address)					
Ethnic Group (optional)(check one box)					
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Asian American/Pacific Islander		<input type="checkbox"/> Black/African American	
<input type="checkbox"/> Mexican American		<input type="checkbox"/> Other Hispanic or Latin American		<input type="checkbox"/> White	
<input type="checkbox"/> Other					
Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male					
Education Level (Optional) Check only one box next to your highest education level completed.					
<input type="checkbox"/> 4th grade or less					
<input type="checkbox"/> Some High School, did not graduate					
<input type="checkbox"/> One or two years of college					
<input type="checkbox"/> Between 5th and 8th grades					
<input type="checkbox"/> High School diploma or GED					
<input type="checkbox"/> Two-year college degree					
*Current Nursing Home Employment Status:					
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed					
(If you are currently working in a nursing home, have your Employer complete Section 2 of this application)					
Do you currently hold a certification as a nurse aide or are you listed on the nurse aide registry in any state other than New York? If yes, list all the states below and indicate if you are in good standing on the Registry in that state. Good standing means that you have no findings or convictions of resident abuse, neglect or misappropriation of resident belongings. Add an additional sheet of paper if more space is required.					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Issuing State	Good standing?	Issuing State	Good standing?	Issuing State	Good standing?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Certification Option/Eligibility

Please check a certification route.

<input checked="" type="checkbox"/>	*Certification Route
	Route 1. New Nurse Aides
	Route 2. Reciprocity/CNA From Another State
	Route 3. Graduate Nurses
	Route 4. RNs and LPNs licensed in the U.S. Enter RN/LPN License Number: _____
	Route 5. Foreign-Trained Nurses
	Route 6. Trained and Lapsed Enter NYS Nurse Aide Certificate Number: _____
	Route 7. Lapsed—Other Enter NYS Nurse Aide Certification Number: _____

Training Information

This section must be completed by the Training Program Coordinator for any applicant who has checked Certification Routes 1, 3, 5 or 7.

*Training Program Code Number: 33□□□□□		*Expected Program Completion Date: (MONTH/DAY/YEAR) □□/□□/□□□□	
*Name of Training Program			
*Training Program Mailing Address (Street Address or P.O. Box)			
City		State	ZIP Code
□□		□□	□□□□□
I certify that this applicant has successfully completed a state-approved nurse aide training program.			
Training Instructors Name:		Training Instructor Signature:	

Employment Information

This section must be completed by your employer if you are employed in NYS by a Health Care Provider with a Nurse Aide Employer Facility Code.

*Employer Facility Code Number: 33□□□□□		*Date of Hire: (MONTH/DAY/YEAR) □□/□□/□□□□	
*What Type of Nurse Aide Employer is the Facility? <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospital <input type="checkbox"/> Staff Agency <input type="checkbox"/> Other			
*Name of Facility or Agency Where Employed			
*Facility Address (Street Address or P.O. Box)			
City	State	County (first four letters only)	ZIP Code
□□□□□	□□	□□□□	□□□□□
*Employer Phone Number (including area code) ()		*Name of Supervisor	
*Employer's Signature		Date □□/□□/□□□□	

Test Site Information

*Please check one of the following options.

<input checked="" type="checkbox"/>	Test Site	
<input type="checkbox"/>	Testing at your Facility: My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator (do not send it to Prometric).	
<input type="checkbox"/>	Regional Test Site: I am applying to test at a Regional Test Site. My preferred test site code is listed. I can find a current list of Test Sites with codes online at www.prometric.com/NurseAide/NY .	*Test site code:

Exam Selection and Processing/Exam Fees

- Acceptable Forms of Fee(s) Payment: certified check, money order Make certified checks payable to New York State Commissioner of Health, NYNA. Personal checks and cash are not accepted. Fees are non-transferrable.
- The Payment Form (last page) must be submitted with this application regardless of payment type.

<input checked="" type="checkbox"/>	First-Time Tester	Fee	Total
	Clinical Skills Test AND Written Test	\$115	\$
	Clinical Skills AND Oral Test (MUST submit ADA Packet)	\$115	\$
	Clinical Skills AND Oral Test (with Reading Comprehension)	\$135	
<input checked="" type="checkbox"/>	Re-tester	Fee	
	Clinical Skills Retest (Prometric ID Number: _____)	\$68	
	Written Retest ONLY (Prometric ID Number: _____)	\$57	\$
	Oral Retest ONLY (Prometric ID Number: _____)	\$67	\$
<input checked="" type="checkbox"/>	Rescheduling/No Show ²	Fee	
	Clinical Skills Test	\$68	\$
	Written Test	\$57	\$
	Oral Test	\$67	\$
<input checked="" type="checkbox"/>	Additional Services	Fee	
	Reciprocity/CNA From Another State and NYS RNs and LPNs Application Processing	\$50	\$
		Total Fee	\$

An additional rescheduling/no show fee of \$25 is required to reschedule an exam appointment with less than five business days notice, no-shows, late arrivals, or not allowed to test. Reschedule fees may apply to roster changes made by IFT testing locations.

Applicant's Affidavit and Candidate Release Statement

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand if information given is not true, my registration status as a nursing assistant may be at risk.
- I agree the New York State Division of Residential Care and Service may investigate the information in this application
- I understand that if I have given false information in this application, my nurse aide certification may be invalidated and I could be prosecuted by New York State. Further, I understand that if I cheat or engage in other prohibited behavior during the exam I may be disqualified from continuing to take the exam or my exam results may be invalidated.
- I understand that a record of the successful completion of this competency evaluation and information from and contained on this form will be included in my record in the New York State Nursing Home Nurse Aide Registry.
- I understand that I may be asked to play the part of the resident for another candidate on exam day.
- I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the New York State Department of Health, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand exam results will be sent to my approved training program and/or employing nursing home (when applicable).
- I understand all information required on the registration application may be made available for public disclosure (except for the Social Security Number).
- I have read and I understand the information in the New York State Nursing Home Nurse Aide Certification Handbook.

*Candidate Signature (in box below)

Date: _____

If you DO NOT receive your emailed ATT letter from Prometric within 10-14 business days of receipt at Prometric, please contact Prometric.

Questions: For additional information, please visit our website at www.prometric.com/nurseaide.

Please make a copy of all completed forms for your personal records.



Payment Form

*Candidate Name: _____

*Date of Birth: _____

Certified Check or Money Order Payments (Check One)

- Certified Check 3rd Party/Facility Check Money Order Voucher/Purchase Order

Certified Check/Money Order/3 rd Party/Facility Check Number /Voucher/Purchase Order (one number or letter in each box):
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Fee(s) may be paid by money order or certified check made payable to "NY Commissioner of Health, NYNA". Your name and ID (if available) must be written on the form of payment. Personal checks and cash are not accepted.

Please mail completed forms, all supporting documentation and fees/letters of Intent to Hire to:

Prometric
ATTN: NY Nurse Aide Program
6211 Greenleigh Avenue
Suite 400
Middle River, MD 21220