Washington, D.C. Home Health Aide Program

NNAAP® EXAMINATION APPLICATION

PLEASE PRINT LEGIBLY — USE INK ONLY

This registration form must be completed if you wish to take the NNAAP® Examination. You are responsible for completing the form. You may ask your employer or someone from your training program for assistance in completing the form. The personal information will only be used to determine your eligibility to test. Failure to provide complete and accurate information may delay your nurse aide test or prevent your entry on the DC Home Health Aide Registry.

IF YOU ARE OR HAVE EVER BEEN AN RN/LPN, please contact the DC Board of Nursing at bonita.jenkins@dc.gov or angela.braxton2@dc.gov for approval prior to sending in this application.

1. PERSONAL INFORMATION Enter the requested information on the appropriate line. Enter your name as you would like it to appear on your nurse aide registration. An identification number is needed to process your application. If you do not have a Social Security number, please check the box below. By checking the box as indicated you are acknowledging that you would like a nine-digit number to be assigned for Registry purposes.

Social Security Number: ___ - __ - ____ ☐ I don't currently have a Social Security Number. I understand that I will be required to have a Social Security number within my two-year certification period.

Date of Birth: __ / __ / ____ (M M / D D / Y Y Y Y) Gender: ☐ FEMALE ☐ MALE

CURRENT Legal Name: DO NOT USE NICKNAMES

LAST FIRST MI

MAIDEN Name: *(if applicable)*

Mailing Address:

STREET (number and name) APARTMENT NUMBER PO BOX

CITY STATE ZIP CODE *(MUST be completely filled out)*

Home Phone Number: ___ - ___ - ____ (AREA CODE) Work Phone Number: ___ - ___ - ____ (AREA CODE)

Ethnic Group *(optional)*. *Please mark only one.*

☐ American Indian/Alaskan Native ☐ Black (Non-Hispanic)/African American ☐ Hispanic
☐ Asian American ☐ Caucasian (Non-Hispanic) ☐ Other

2. EXAMINATION TYPE AND FEES *(check only one box)*

Check the box indicating the exam that you need to take. If you are applying for first time, you must take both the Written (or Oral) Examination and the Skills Evaluation. You must choose between the Written Examination and the Oral Examination; you may not register for both. (For more information about the Oral Examination, refer to the District of Columbia Nurse Aide Candidate Handbook.)

Exam Type	Check/MO	Credit Card
☐ 1. Written Exam and Skills Evaluation *(first time)*	$105.00	$108.75
☐ 2. English-Oral Exam and Skills Evaluation *(first time)*	$105.00	$108.75
☐ 3. Written Exam and Skills Evaluation *(re-test)*	$105.00	$108.75
☐ 4. English-Oral Exam and Skills Evaluation *(re-test)*	$105.00	$108.75
☐ 5. Written Exam *ONLY*	$ 40.00	$ 41.50
☐ 6. English-Oral Exam *ONLY*	$ 40.00	$ 41.50
☐ 7. Skills Evaluation *ONLY*	$ 65.00	$ 67.25

Amount enclosed : $ ___ . __

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Examination fee: Must be paid in the form of a certified check, company check, credit card, or money order, made payable to "American Red Cross" (ARC). NO PERSONAL CHECKS OR CASH ACCEPTED. FEES ARE NON-REFUNDABLE ONCE SUBMITTED BECAUSE THEY COVER THE ADMINISTRATION COSTS OF REGISTRATION AND TESTING.

Credit Card Payment: MasterCard and Visa credit cards are accepted. The request for approval of credit card payments will be done only once. If card is declined, an alternate form of payment is required. Print and sign your name as it appears on your card. Indicate the credit card selection, credit card number, and expiration date. If paying by credit card, you may fax your application to the American Red Cross at (866) 257-6506.

Name *(Print)*: _____ Signature: _____

☐ Mastercard ☐ Visa Credit Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date ☐☐/☐☐

3. ELIGIBILITY ROUTE INFORMATION *(check only one box)*

☐ **H1 – I have completed an approved DC Home Health Aide training program within the last twenty-four (24) months.**

☐ **I have enclosed a photocopy of my home health aide training completion certificate,** issued within the last twenty-four (24) months by an approved DC home health aide training program.

HHA Training Program Code: ☐☐☐☐☐ **Date Completed Training :** ☐☐ / ☐☐ / ☐☐☐☐
M M D D Y Y Y Y

☐ **H2 – I am a CNA and have completed the Home Health Aide bridge course.**

CNA Registry Number: ☐☐☐☐☐☐☐☐ **CNA Expiration Date:** ☐☐ / ☐☐ / ☐☐☐☐
M M D D Y Y Y Y

HHA Training Program Code: ☐☐☐☐☐ **Date Completed Training :** ☐☐ / ☐☐ / ☐☐☐☐
M M D D Y Y Y Y

☐ **H3 – I completed an approved Nursing Assistant course and a Home Health Aide bridge course but have not tested.**

☐ **I have enclosed a photocopy of my Nursing Assistant Training Program Certificate.**

☐ **I have enclosed a photocopy of my Home Health Aide Training Program Certificate.**

☐ **H4 – I am currently a Student Nurse**

☐ **I have enclosed a photocopy of my student nurse transcript showing Fundamentals of Nursing completed.**

☐ **H5 – I have trained as an RN and LPN outside the United Stats and have no United States nursing license.**

☐ **I have enclosed a copy of my foreign credentials certification.**

PLEASE REVIEW YOUR APPLICATION. BE SURE IT IS CORRECT AND ACCURATE. IF YOUR FORM IS INCOMPLETE, OR YOU HAVE NOT ENCLOSED THE CORRECT EXAMINATION FEES, OR YOU HAVE NOT ATTACHED A COPY OF THE REQUIRED DOCUMENTATION, YOUR APPLICATION WILL BE RETURNED TO YOU. THIS WILL DELAY YOUR REGISTRATION. THE AMERICAN RED CROSS IS NOT RESPONSIBLE FOR MISDIRECTED MAIL.

6. REGISTRANT CERTIFICATION

I hereby certify that the information provided on this registration form is true and accurate, and that I am the person whose name appears on the form.

_____

SIGNATURE DATE

Mail your completed application, including all required documentation and fees to:

American Red Cross
1804 North Sixth Street
Harrisburg, PA 17102

For test scheduling inquiries, please call: (888) 399-7729.