

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION & LICENSING ADMINISTRATION

APPLICATION FOR CERTIFICATION



BOARD OF NURSING
HOME HEALTH AIDE

DO NOT SUBMIT THIS APPLICATION UNTIL YOU HAVE PASSED THE HHA EXAM

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HRLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST. **Please Note: Please refer to application instructions before completing this form.**

SECTION 1A. CERTIFICATION FEE

Check or money order payable to: DC Treasurer
Mail to: HRLA 2 – P.O. Box 37802 – Washington, D.C. 20013

Home Health Aide Certification: \$50.00

CRIMINAL BACKGROUND CHECK (Fingerprinting):

PLEASE NOTE: Schedule fingerprinting after you have submitted your HHA application and received your certificate number. Your HHA certificate number will be required for fingerprinting.

For payment and to schedule an appointment call

1-877-783-4187 or visit www.LIenrollment.com

CRIMINAL BACKGROUND CHECK (Fingerprinting) previously completed:

If you have previously completed fingerprinting by MorphoTrust for the National Criminal Background Program and/or licensure/ certification by DC Health Regulation & Licensing Administration (If this applies to you, another CBC is not required.)

All applicants are required to undergo a Criminal Background Check

Check the box to indicate your status and attach the supporting document(s):

Completion of home health aide program (with-in the last 24 months) approved by the Board or a nursing board in the United States, equivalent to the DC Board of Nursing standards.

-or-

Completion of a practical or registered nursing "Fundamentals of Nursing" course with clinical components (in the United States) within the last thirty-six (36) months from the date of the application.

-or-

The Commission on Graduates of Foreign Nursing Schools certificate, received within the last thirty-six (36) months from the date of application of certification, indicating education as a registered nurse (RN) or licensed practical nurse (LPN) outside the United States.

SECTION 2A. APPLICANT INFORMATION

LEGAL NAME: (Do not use initials unless they are a part of your name)

FIRST NAME MI LAST NAME (SUFFIX: Jr., Sr. etc.)

Date of Birth

_____-_____-_____
Social Security Number *

GENDER: MALE FEMALE

Place of Birth: State/Providence/Territory

Place of Birth: Country if not USA

*All Applicants must provide a Social Security Number. If you are a foreign applicant and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your certification will not be renewed without a valid SSN. You can download the affidavit form by accessing it at www.HRLA.doh.dc.gov

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STATE	Type of Certification	ACTIVE/ NOT ACTIVE	CERTIFICATION NUMBER (if applicable)

SECTION 4. FEES AND SUPPORTING DOCUMENTS

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- HOME HEALTH AIDE CERTIFICATION FEE:** \$50.00
- CRIMINAL BACKGROUND CHECK:** -To schedule your live scan fingerprints visit www.l1enrollment.com [MorphoTrust] or call 1-877-783-4187. For questions contact the CBC unit at 202-442-9004.
Please Note: You must submit this application and obtain your certification number prior to registering for your fingerprint live scan. You can obtain your certification number at <http://app.HRLA.doh.dc.gov/weblookup> 72 hours after your application has been submitted.

**Your application along with all required supporting documents must be mailed from your school to the Board office.
Schools: Please mail in a 9X12 inch envelope and do not staple or fold application.**

- PASSPORT-TYPE PHOTOS:** Two recent and identical passport-type photos of the applicant’s face (approx. 2”X2”) with applicant’s name written on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.
- COPY OF LEGAL DOCUMENT:** Provide legal documents supporting name change (if applicable). Acceptable documents are marriage certificate, divorce decree, court order or spouse’s death certificate.
- SOCIAL SECURITY NUMBER AFFIDAVIT FORM** (if no SSN issued) This document can be found at www.HRLA.doh.dc.gov
- COPY OF HHA TRAINING PROGRAM CERTIFICATE.** In addition, your name must appear on the list of graduates Previously submitted by your HHA training programs.
- PROVIDE A DETAILED EXPLANATION:** If you answer “Yes” to any of the questions in Section 5 (next page).
Clean Hands: If you owe the District of Columbia more than \$100. Submit proof of payment arrangements you have made with the agency to pay our outstanding debt.
Disciplinary actions: If you have had actions taken against your license/certification (asked to withdraw, suspension, probation, revocation) provide documentation detailing the resolution of the discipline.
Arrest/conviction: If you have been arrested or convicted within the last seven (7) years, submit court documents pertaining to each arrest and/or conviction which provides information regarding the outcome of final decision.

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SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your Certification** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be certified if you have failed to file your District tax returns. IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

YES NO

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

Information presented above is in compliance with the requirement to submit with your application for licensure under

- A. Has the use of drugs and/or alcohol resulted in an impairment of your ability to safely provide patient care? YES NO
- B. Do you have a mental condition that currently impairs your ability to safely provide patient care? YES NO
- C. Have you ever been arrested, or pled guilty instead of going to trial, or been found guilty after a trial, or pled nolo contendere, regardless of whether the arrest, conviction or plea of nolo contendere was sealed or expunged? *If you answer "Yes" to this question, include all court documents pertaining to each arrest and/or conviction that occurred within the last seven (7) years, which detail the outcome or final decision.* YES NO
- D. Please answer with respect to DC or any other jurisdiction/state: YES NO
- (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license/certification after formal charges have been filed against you or while under investigation?
- (2) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?

SECTION 6. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

SIGNATURE

PRINT NAME

DATE

PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.