



**District of Columbia
Health Professional Licensing Administration
Board of Nursing**

HOME HEALTH AIDE ATTESTATION OF TRAINING AND COMPETENCE

Name of HHA Applicant	Place of Employment (name of office/agency/facility)	Location of Employer	Hire Date End Date
			/ / MM DD YYYY / / MM DD YYYY

I, this APPLICANT'S EMPLOYER, confirm that this applicant has successfully completed training as a Home Health Aide at the following training program:

I, this APPLICANT'S EMPLOYER, confirm that to the best of my knowledge, this applicant is competent to provide patient care: Yes No

I, the APPLICANT'S EMPLOYER, confirm that this applicant at least 500 hours as a HHA.
 Yes No (If no, how many hours has this applicant worked in your employ? _____)

Employer: _____
 [Print your name]

By signing this attestation, I, _____, hereby attest that the information that I have provided on this Attestation Experience Form is true and complete to the best of my knowledge.

I, this APPLICANT'S SUPERVISING NURSE/HEALTH PROFESSIONAL, confirm that this applicant is competent to provide patient care. Yes No

Supervising Nurse/ Health Professional: _____
 [Print your name]

License Number: _____

By signing this attestation, I, _____, hereby attest that the information that I have provided on this Attestation Experience Form is true and complete to the best of my knowledge. I understand that making a false statement on this document, including all writings and attachments, may result in the Department of Health taking action against me that it deems appropriate.