



**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF NURSING**

REINSTATEMENT OF EXPIRED HOME HEALTH AIDE CERTIFICATION

Thank you for submitting an application to reinstate your Home Health Aide Certification (HHA) in the District of Columbia. In this package you will find the instructions and the application for you to fill out and submit to the Board of Nursing to reinstate your certification. Please read everything carefully before you fill out the application.

Definition of Reinstatement

Reissuance of an expired HHA certificate

[This is the process of making your expired certification active which will allow you to work].

Requirements for Reinstatement of Expired Home Health Aide Certification

Our Home Health Aide regulations state that if a home health aide fails to renew her or his certification the Board can reinstate the certification if the applicant:

- (a) Submits a completed reinstatement application and
- (b) Submits proof (documents/papers), with their name on it, indicating completion of twelve (12) hours of in-service or continuing education completed within the last twelve (12) months.

THE APPLICATION PROCESS

Upon submission of this application and required documents, the District of Columbia Board of Nursing will review your application and upon approval, issue you a certification to practice in the District of Columbia. If you submit an application that is incomplete or otherwise deficient you will be notified. If the Board has questions or concerns, you will also be notified.

GENERAL REQUIREMENTS FOR ALL APPLICANTS

All applicants must submit the following in order to be considered for licensure:

- a. A complete and signed application, including required supporting documents; and
- b. Two passport-type photos of the applicant's face, measuring approximately 2" x 2" with the applicant's name printed on the back. Home snapshots are not acceptable.

WHERE TO FILE

Application and documents should be sent to the following address:

Board of Nursing
P. O. Box 37802
Washington, D.C. 20013

If you have any questions, call HRLA's Customer Service toll free line at 1-877-672-2174 between 8:30 a.m. and 4:30 p.m. EST Monday through Friday. Please read these instructions carefully to facilitate prompt processing of your application. Illegible applications and applications submitted without required signatures or with incorrect fees will be returned in their entirety, including fees. Please print or type all information except signatures.

COMPLETING THE LICENSE APPLICATION

Section 1. Applicant Information

Please read this section carefully. Enter your name, address, social security number and other requested information. If updated check the box provided. If your last active certification was issued in another name, you must provide (with this application) a copy of a legal name change document. Acceptable documents include a marriage certificate, divorce decree, court order or spouse's death certificate.

Section 2. Criminal Background Check (CBC)

If you previously completed a Criminal Background Check (CBC) for the purpose of licensure that yielded FBI and State results, you are not required to repeat the CBC.

Section 3. Certification Reinstatement Fee

a. There is one license type to choose:
HHA Reinstatement

b. You may pay the reinstatement fee by a single check or money order. Checks or money orders should be made payable to DC Treasurer and submitted with your application packet. Do **NOT** send cash. Please print your name on your check, if it is not pre-printed.

Section 4. Questions:

You must answer all of the questions

If you answer "yes" to questions A through G, please provide a complete explanation on a separate sheet of paper. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514.

PLEASE NOTE: If you have been convicted of a crime or have had actions taken against your license, please provide court papers which detail the outcome or current status of the case.

Section 5. Applicant Affidavit

By signing the application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge.



District of Columbia
 DEPARTMENT OF HEALTH – HEALTH REGULATION AND LICENSING ADMINISTRATION
HHA REINSTATEMENT APPLICATION

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Please read instructions at the beginning of each section as you complete this form. See Section 2 for special information specific to your license. If you have any questions, call HRLA's Customer Service line Monday through Friday, 8:30 AM to 4:30PM EST at 1-877-672-2174.

A Charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)

SECTION 1. APPLICANT INFORMATION – Please provide the information requested below. If updated, check box provided at right. If you are changing your name, you must provide legal documentation for the name change. Acceptable documentation for individuals includes a copy of a marriage certificate, divorce decree, or court order.

Keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify the Board of any address change within 30 days of the change.

PLEASE PRINT

Name change due to: Marriage Divorce Court Order

Full Name: _____ License Number: _____

Mailing Address: _____ *SSN: _____

City/State/Zip Code: _____ Birth date: _____

Phone: _____ Business Phone: _____

E-mail: _____ Business E-mail: _____

*Pursuant to D.C. Official Code Section 3-1205.5(b) (2001) (Health Occupations Revision Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license.

SECTION 2. CRIMINAL BACKGROUND CHECK (CBC)

IF YOU COMPLETED A CBC FOR THE PURPOSE OF LICENSURE THAT YIELDED FBI AND STATE RESULTS, YOU ARE NOT REQUIRED TO REPEAT THE CBC.

REQUIREMENTS FOR REINSTATEMENT

DURING THE PERIOD PRIOR TO REINSTATEMENT HHAs must:

Have completed twelve (12) hours of in-service training or other continuing education within one (1) year before turning in this application.

SECTION 3. REINSTATEMENT FEES

Please check the appropriate box

FEE

Make check or money order payable to DC TREASURER and Mail to:

HHA Reinstatement \$70.00

DC Board of Nursing
 P.O. Box 37802
 Washington, DC 20013
 Phone: 1-877-672-2174
 Website: www.doh.dc.gov

SECTION 4. Questions – Applicants **MUST answer all of the following questions.**

Answer questions A through H by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

A. 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 License or Permit** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).
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 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:

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)?

YES NO

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

B. Since your last certification, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C. Since your last certification: (1) Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) 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? (4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?	YES <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	NO <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
D. Do you have a physical or mental condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E. Since your last certification, have you been diagnosed or treated for substance abuse?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F. Since your last certification, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G. Since your last certification, have you been terminated or asked to resign from employment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H. I have completed 12 hours of in service training or other continuing education during the last year.	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION 5. APPLICANT 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.

 APPLICANT SIGNATURE

 APPLICANT NAME (Please print)

 DATE

Please keep a copy of this Reinstatement application and your payment for your records.