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

APPLICATION FOR CERTIFICATION BY REINSTATEMENT OR REACTIVATION

Health Regulation and Licensing Administration
899 North Capitol Street, N.E.; 1st Floor
Washington, DC 20002
Email: dc.bon@dc.gov

DISTRICT OF COLUMBIA BOARD OF NURSING

Your interest in reinstating your certification in the District of Columbia is welcomed. We look forward to providing expedient and professional service. However, the quality of our service is dependent on the completeness of your application. Please read the instructions carefully.

Follow the instructions provided below and complete all sections. If you require more space to provide explanations for screening questions, attach typed responses to the application.

THE APPLICATION PROCESS

The District of Columbia Board of Nursing will review your application. You will be notified if your application is incomplete or otherwise deficient. Upon final approval, you will be able to verify your licensure status at http://app.hpla.doh.dc.gov/weblookup/ and you will be issued a certification to practice in the District of Columbia. Send your questions to dc.bon@dc.gov.

REINSTATEMENT OF AN EXPIRED CERTIFICATION

Definition of Reinstatement
Reissuance of an expired HHA certificate [The process of making your expired certification active and allow you to work].

Requirements for Reinstatement of Expired Home Health Aide Certification
DC Board of Nursing Home Health Aide regulations state that if a home health aide fails to renew his or her certification, the Board can reinstate the certification if the applicant:

a. Submits a completed reinstatement application and
b. Submits proof (documents) of completion of twelve (12) hours of in-service or continuing education for each year that the certification was inactive, for a maximum of 24 hours. Each document should have the aide's name, name of the course, and the date completed; and
c. Submit evidence (Employment Attestation Form) of having worked for a minimum of eight (8) hours within the last two years under the supervision of a licensed nurse or other licensed health professional.

Requirements for Reactivation of an Inactive Home Health Aide Certification
To reactivate, the Home Health Aide shall:

a. Submit a completed reinstatement application and
b. Submit evidence of having completed twenty-four (24) hours of continuing education or in-service training within the last twenty-four (24) months.

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COMPLETING THE APPLICATION

Applicant Information

Please read this section carefully. Enter your name, address, social security number and other requested information. 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.

Criminal Background Check (CBC)

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

Certification Reinstatement Fee (non-refundable)

You may pay the reinstatement/reactivation 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.

Screening Questions:

You must answer all of the questions and attach any required supporting documents

If you answer "yes" to question A: Provide 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.

If you answer "yes" to questions B - G: 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.

Applicant Affidavit

Please be informed that by signing this application you are attesting under penalty of perjury that all information and attached documents are true to the best of your knowledge. False statements or documentation may lead to denial of your recertification by the DC Board of Nursing.

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DISTRICT OF COLUMBIA BOARD OF NURSING

LICENSE TYPE:	**FEE (Non-refundable)**
☐ Reinstate expired HHA Certification	$70.00
☐ Reactivate inactive HHA Certification	$34.00

PAYMENT: Make check or money order payable to **DC Treasurer** and mail along with this application to:

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

Please complete and **submit the original application and any supporting documents**. If more space is needed to fully answer the questions, attach additional sheets with typed responses. False or misleading statements may be cause for disciplinary action. If you have any questions **email: dc.bon@dc.gov**

EXPIRATION: **HHA certification expire October 30th of odd-numbered years**

APPLICANT INFORMATION:

LEGAL NAME**:** If your name has changed provide a copy of a legal document supporting the name-change. Acceptable documents are: marriage certificates, divorce decrees, or court orders.

Prefix (Ms., Mrs., Mr., etc.):

First Name: MI:

Last Name: Suffix (Jr., Sr., etc.)

Date of Birth: – –

Social Security Number: – –

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UPDATE HOME ADDRESS OR LOCAL/MAILING ADDRESS: (All official correspondence will be mailed to this address.) **You are statutorily required to notify the Board in writing within 30 days of an address change. Failure to do so may result in non-receipt of a license, renewal notice or other official notices and can result in a disciplinary action or a fine.**

Street Number and Street Name:

Apartment/Suite Number: City:

State/Province/Territory: ZIP:

Phone Number:

Email Address:

UPDATE BUSINESS OR MAILING ADDRESS: (This address will be made available to the public)

Street Number and Street Name:

Apartment/Suite Number: City:

State/Province/Territory/Jurisdiction: ZIP:

Phone Number:

Email Address:

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SCREENING QUESTIONS

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 the Department of Health to proceed immediately to revoke your License 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 issued a license if you have failed to file your District tax returns.

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

***IF YOU ANSWERED " Y E S"** 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.

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

Applicants Must Answer All of the Following Questions. If you answer "Yes" to any of the following questions provide a detailed explanation on a separate sheet of paper. Submit copies of relevant court reports, personnel actions, and actions taken against your license or other relevant documents.

B.	Since you were last licensed, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES NO
C.	Since you were last licensed: (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 certification status? (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 NO
D.	Do you have a physical or mental condition that currently impairs your ability to practice your profession?	YES NO
E.	Since you were last licensed, have you been diagnosed or treated for substance abuse?	YES NO
F.	Since you were last licensed, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case.	YES NO
G.	Since you were last licensed, have you been terminated or asked to resign from employment?	YES NO

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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.

_____ _____

PRINT NAME **DATE**

_____

LICENSEE SIGNATURE

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

Your application along with any <u>required supporting documents</u> must be mailed in the same package to:

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

REPORT FRAUD, WASTE AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General's hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General's website at oig.dc.gov.

IMPORTANT CONTACT INFORMATION

District of Columbia Health Regulation and Licensing Administration

Mailing Address:	District of Columbia Board of Nursing P.O. Box 37802 Washington, D.C. 20013
Application Processing Center:	District of Columbia Department of Health 899 North Capitol Street, NE, 1st Floor Washington, DC 20002
Check Application Status:	https://app.hpla.doh.dc.gov/Weblookup/
Website:	hrla.doh.dc.gov
Board of Nursing Email:	dc.bon@dc.gov

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HOME HEALTH AIDE EMPLOYMENT ATTESTATION FORM

Name of HHA_____

HHA Certification Number _____

Name of Facility _____

Address_____

Supervising Nurse Name _____

RN License Number _____

I, this APPLICANT'S SUPERVISING NURSE, confirm that to the best of my knowledge that this HHA applicant has provided a minimum of eight (8) hours of patient care with the past two years: __ Yes __ No

By signing this attestation,

Supervising Nurse Signature _____Date _____ HHA Signature_____Date _____ I, hereby attest that the information provided on this HHA Employment Attestation Form is true and complete to the best of my knowledge. I understand that making a false statement on this document may result in the Board of Nursing taking any action against me that it deems appropriate.