



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 Nurse Aide Registry.

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.

Social Security Number: -- Date of Birth: // 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.)

- 1. Written Exam and Skills Evaluation (first-time) \$117.00*
- 2. English-Oral Exam and Skills Evaluation (first-time) \$127.00*
- 3. Spanish-Oral Exam and Skills Evaluation (first-time) \$127.00*
- 4. Written Exam and Skills Evaluation (re-test) \$105.00
- 5. English-Oral Exam and Skills Evaluation (re-test) \$115.00
- 6. Spanish-Oral Exam and Skills Evaluation (re-test) \$115.00
- 7. Written Exam ONLY \$40.00
- 8. English-Oral Exam ONLY \$50.00
- 9. Spanish-Oral Exam ONLY \$50.00
- 10. Skills Evaluation ONLY \$65.00

*The fee for the first-time you test includes a (one-time) \$12 Registry placement fee.

Amount enclosed: \$.

Examination fee: Must be paid in the form of a certified check, company check, or money order, made payable to "American Red Cross" (ARC). No personal checks, cash, or credit cards accepted. Fees are non-refundable once submitted because they cover the administration costs of registration and testing.

3. ELIGIBILITY ROUTE INFORMATION (check only one box)

- D1 – I have completed a DC Department of Long Term Care-approved nurse aide training program within the last 24 months, and I am not currently on the DC Nurse Aide Registry or on a nurse aide registry in another state.
 - I have enclosed a photocopy of my nurse aide training completion certificate, issued within the last twenty-four (24) months by an approved DC nurse aide training program.
- D2 – I have completed an equivalent practical nursing or registered nursing Fundamentals of Nursing course with a clinical component within the USA.
 - I have enclosed a photocopy of my official school transcript.

Eligibility Route Information continues on reverse side

- D3 – I am currently an RN or LPN, licensed in Washington, DC.
 - I have enclosed a photocopy of my RN or LPN license.
 - D4 – I trained as an RN or LPN outside of the USA.
 - I have enclosed a photocopy of my foreign certification credentials.
 - D5 – I am taking the NNAAP™ Examination for re-application to become current on the Registry after lapsing. My Registry Certificate has expired *within* the last twenty-four (24) months.
 - I have enclosed a photocopy of my expired Registry Certificate.
- DC Nurse Aide
 Registration ID Number: / /
- Registration Expiration Date: / /
- M M / D D / Y Y Y Y
- D6 – I am taking the NNAAP™ Examination for re-application to become current on the Registry after lapsing. My Registry Certificate has expired *more than* twenty-four (24) months ago and I have completed an approved nurse aide training program.
 - I have enclosed a photocopy of my expired Registry Certificate.
 - I have enclosed a photocopy of my nurse aide training completion certificate, issued within the last twenty-four (24) months by an approved DC nurse aide training program.
- DC Nurse Aide
 Registration ID Number: / /
- Registration Expiration Date: / /
- M M / D D / Y Y Y Y
- D7 – I am currently in good standing on another state’s registry and I’m applying for reciprocity by examination.
 - I have enclosed a photocopy of my out-of-state Registry Certificate.

4. TRAINING PROGRAM INFORMATION

Enter the name of the DC Department of Long Term Care-approved training program where you completed your nurse aide training. If you fall under one of the following eligibility routes, please use the code indicated below:

- | | |
|--|--|
| D2 – Student Nurse. 99994 | D5 – Lapsed Nurse Aide—less than 24 months . . . 99995 |
| D3 – RN or LPN 99990 | D7 – Reciprocity by Examination 99998 |
| D4 – Trained as an RN or LPN outside of USA. . . . 99910 | |

Name of Training Program:

Training Program Code: Date Completed Training: / /

M M / D D / Y Y Y Y

5. EMPLOYMENT INFORMATION

Enter the nursing facility/employer name, code and date of hire where you are currently employed. (You are considered employed if you are being paid by a health care provider.) If you are not working as a Nurse Aide, print “UNEMPLOYED” in the space labeled “Nursing Facility/Employer” and enter 99996 as your “Nursing Facility/Employer Code”.

Name of Facility/Employer:

Nursing Facility/Employer Code: Date of Hire: / /

M M / D D / Y Y Y Y

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:

If using US Mail service, mail to:
American Red Cross
 PO Box 5875
 Harrisburg, PA 17110

If using an overnight courier service, send to:
American Red Cross
 1804 North Sixth Street
 Harrisburg, PA 17102

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