NURSE AIDE COMPETENCY EVALUATION APPLICATION

State Form 43731 (R4/09-00)
Indiana State Department of Health-Division of Long Term Care

Your Social Security Number is being requested by this State Agency in accordance with 42 CFR 483.156(c)(1)(ii). Disclosure is mandatory, and this application cannot be processed without it.

SECTION I - APPLICANT INFORMATION

Name of Applicant			Social Security Number
Street Address			
City	State	County	Zip Code +4
Date of Birth *(mm/dd/yr)*	Date of Hire *(mm/dd/yr)*	QMA number	

SECTION II - COURSE INFORMATION (30 HOUR CLASSROOM EDUCATION)

Name of Facility/School			Telephone Number *(area code)*
Street Address			Facility Number
City	State	County	Zip Code+4
Date of Classroom Completion *(mm/dd/yr)*	Program Director *(printed)*		

I verify that the above named applicant has successfully completed at least 30 hours of classroom instruction utilizing the Indiana State Department of Health (ISDH) approved standards and resident care procedures and that a summary of all assessment tools and the RCP checklist are completed and available in this applicant's file.

Program Director's Signature	Date *(mm/dd/yr)*

SECTION III – COURSE INFORMATION (75 HOUR CLINICAL EXPERIENCE)

Name of Facility			Telephone Number *(area code)*
Street Address			Facility Number
City	State	County	Zip Code+4
Date of Clinical Completion *(mm/dd/yr)*	Supervisor *(printed)*		

I verify that the above named applicant has successfully completed at least 75 hours of clinical experience supervised by a licensed nurse utilizing Indiana State Department of Health (ISDH) approved resident care procedures and that a summary of the RCP checklist are completed and available in this applicant's file.

Clinical Supervisor's Signature	Date *(mm/dd/yr)*

I verify that the above information is correct

Applicant's Signature	Telephone Number *(area code)*	Date *(mm/dd/yr)*

SECTION IV - APPLICANT'S TEST STATUS

❒ Completed Indiana 105 hour Training

❒ Foreign Nurse *(country)*_____

❒ Transferring From SLO

❒ Student Nurse *(school)*_____
(currently enrolled nursing student)

❒ Psychiatric Attendant

❒ Graduate Nurse
waiting to: take Boards_____ retake Boards_____

❒ Out of State CNA Verification *(name of state)*_____

❒ Other_____

SECTION V - TEST/MONITOR INFORMATION

TEST NO. 1

Test Entity		
Test Monitor		
Test Site		Test Date *(mm/dd/yr)*
Written Test ❒ Pass ❒ Fail	Oral Test ❒ Pass ❒ Fail	Skills Test ❒ Pass ❒ Fail

TEST NO. 2

Test Entity		
Test Monitor		
Test Site		Test Date *(mm/dd/yr)*
Written Test ❒ Pass ❒ Fail	Oral Test ❒ Pass ❒ Fail	Skills Test ❒ Pass ❒ Fail

TEST NO. 3

Test Entity		
Test Monitor		
Test Site		Test Date *(mm/dd/yr)*
Written Test ❒ Pass ❒ Fail	Oral Test ❒ Pass ❒ Fail	Skills Test ❒ Pass ❒ Fail