



**CHECKLIST INSTRUCTIONS**  
**REINSTATEMENT OF ADVANCED NURSE AIDE**  
**CERTIFICATION**

Enclosed Fee:  \$30 (Non-refundable)

Fee is payable by check or money order to: *Treasurer of Virginia*

Pursuant to Virginia nursing regulation [18 VAC 90-25-120](#) if an advanced nurse aide certificate has lapsed for more than ninety (90) days an application for reinstatement is required.

**To be eligible for reinstatement of an advanced nurse-aide certificate you must:** (1) hold a current nurse aide certificate; and (2) have completed the required continuing education/training for advanced nurse aides (includes: three contact hours per year of continuing education and training in any of the competency areas identified in the advanced certification training program) within the two years preceding the expiration of your advanced nurse aide certificate AND within two years of from the date the Board of Nursing receives your reinstatement application.

**Note:** Applications and fees are only retained for one (1) year only. If not all requirements are met within 1 year of the Board receiving the application and fee, a new application and fee will be required.

**REQUIREMENTS BELOW - Check COMPLETED applicable items that are included with your application:**

**Completed Reinstatement Application and required Fee (\$30):** Fees must be paid by check or money order, made payable to *The Treasurer of Virginia*. An application will not be reviewed or considered until payment is submitted. **Fees are non-refundable.**

**Current nurse aide certificate**

**Completed continued competency requirements:** Provide evidence of completing **at least three (3) contact hours per year** of continuing education and training in any of the competency areas identified in the advanced certification training program as specified [18VAC90-25-120](#) in during the two (2) years immediately preceding application for reinstatement.

**I have completed the continued competency requirements.**

**OR (If Applicable)**

**By checking this box, I am requesting the Board waive or extend the continued competency requirements under 18 VAC 90-25-120 (B) 2. I have provided detailed circumstances attached to this application to support this request. I understand that the Board may deny my request to waive these requirements in determining eligibility for reinstatement of my advanced nurse aide certification.**

**I have enclosed from the clerk(s) of court, certified copies of all criminal conviction records OR if court records have been destroyed, a certified statement from the court stating records are no longer available.**

Additional Information:

- The VBON may request additional evidence that the nurse aide is prepared to resume practice in a safe, competent manner.
- Application processing times are between 30-45 **business** days to complete.
- Check your license/certificate/registration status by going to: [License Lookup](#) (\*license information is posted in real time).
- Nursing laws and regulations may be obtained at <http://www.dhp.virginia.gov/Boards/Nursing/>
- Documents submitted with the application are property of the Board and cannot be returned.

**THIS COMPLETED INSTRUCTION CHECKLIST MUST BE SUBMITTED WITH APPLICATION**



Nurse Aide Registry  
 9960 Mayland Drive  
 Suite 300  
 Perimeter Center  
 Henrico, Virginia 23233  
 (804) 367-4515

**APPLICATION FOR REINSTATEMENT  
 ADVANCED NURSE AIDE CERTIFICATE**

**Check One (Fee is \$30):**

- Reinstatement of Lapsed (Expired) Certificate
- Reinstatement After Suspension or Revocation of Certificate

*To Be Completed by Finance Division*

*To Be Completed by Board of Nursing Staff*

Fee \$30

Receipt #:

Date Received:

Date Certified:

**INCLUDE A \$30 CHECK OR MONEY ORDER MADE PAYABLE TO: TREASURER OF VIRGINIA  
 THIS APPLICATION FEE IS NONREFUNDABLE- PLEASE MAIL: A FAXED APPLICATION CANNOT BE ACCEPTED**

**Disclosure of Addresses**

Pursuant to [Virginia Code § 54.1-2400.02](#) addresses of licensees are made available to the public. Normally, the Address of Record is the publicly disclosed address. If you do not want your Address of Record to be made public, you may provide a second, publicly disclosable address (e.g. work or practice address). If you would like your Address of Record to be publically available complete both sections with same address.

**Disclosure of Social Security or DMV Control Numbers**

Pursuant to [Virginia Code § 54.1-116 \(A\)](#), you are required to submit your social security number or your control number issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided for by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.

**APPLICANT INFORMATION**

|   |  |                                 |  |        |                       |                             |  |   |  |
|---|--|---------------------------------|--|--------|-----------------------|-----------------------------|--|---|--|
| Name – Last   |  | First                           |  | Middle |                       | Maiden                      |  |   |  |
| * Current MAILING Address/Address of Record (Include Apt./Lot Number) |  |                                 |  | City   |                       | State                       |  | Zip Code  |  |
| Publicly Disclosable Address (e.g. work or practice location)         |  |                                 |  | City   |                       | State                       |  | Zip Code  |  |
| Date of Birth   |  | **Social Security or DMV Number |  |        |                       | Virginia Certificate Number |  |   |  |
|   |  |                                 |  |        |                       | 1401-                       |  |   |  |
| E-mail address:   |  |                                 |  |        | Telephone Number      |                             |  |   |  |
| School Name of Nurse Aide Education Program                           |  |                                 |  |        | Location (City/State) |                             |  | Date of Graduation<br>(At least year graduated) |  |

**Name(s) on registry if does not match name provided above:**

|      |  |       |  |        |  |        |  |
|------|--|-------|--|--------|--|--------|--|
| Last |  | First |  | Middle |  | Maiden |  |
|------|--|-------|--|--------|--|--------|--|

**If name has changed since receiving your MOST CURRENT certificate to practice as a certified nurse aide or advance practice certificate, submit a copy of the marriage certificate or court order authorizing the change of name (i.e., divorce decree, immigration papers, etc.) with this application. YOUR NAME CANNOT BE CHANGED WITHOUT THIS DOCUMENTATION.**

**MARK THE APPROPRIATE RESPONSE TO THE FOLLOWING QUESTIONS:**

1. Have you ever been convicted, pled guilty to, or pled no contest to the violation of any federal, state, or other law constituting a felony or misdemeanor, including convictions for driving under the influence (DUI) but excluding traffic violations?

Yes\*  \*Information Previously Provided  No

If YES, detail facts, circumstances about the situation and steps taken to ensure that it does not happen again in Explanation Section.

**Submit:** all certified court documents from the clerk of the court for each conviction to include proof of fines paid, restitution, probation reports, completion of community service, VASAP etc. OR if court records have been destroyed by the court, submit a certified statement from the court stating records are no longer available.

2. Have you ever had action taken against or been denied a license or certificate in a health-related field?  Yes  No

If YES, facts, circumstances about the situation and steps taken to ensure that it does not happen again in Explanation Section.

**Submit:** copy of all orders/actions.

**Respond in full to the following questions. You may provide required details in the Explanation section on page 3**

1. Within the past five (5) years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?  Yes  No

A. If YES, detail under Explanation section.

B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior?  Yes  No

2. Within the past five (5) years, have you been disciplined by any entity?  Yes  No

A. If YES, detail under Explanation section and provide any associated orders or letter from entity.

B. Within the past five (5) years, have you sought or been directed to seek treatment for your conduct or behavior?  Yes  No

3. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a nurse aide.  Yes  No

A. If YES, detail under Explanation section. (Note: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).

4. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a nurse aide.  Yes  No

A. If YES, detail under Explanation section. (Note: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).

5. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a nurse aide?  Yes  No

A. If YES, detail under Explanation section. (Note: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board).

6. Within the past five (5) years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?  Yes  No

A. If YES, detail under Explanation section. (Note: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application or have the program send this documentation directly to the Board).

**If you answered any of the above questions that require additional information, provide details in the Explanation Section (page 3 below) and have certified copies sent directly from the court of any applicable court documents, Board Orders, etc. sent directly to the VBON.**

**Continued Competency Requirements:** Please provide evidence that you have completed **at least three contact hours per each year your certificate has been expired** through submission of a letter from your supervisor on company letterhead OR a request for the Board to consider an extension or waiver of such continuing education requirements based upon the following good cause: (Attach additional pages, if necessary)

**EXPLANATION SECTION** may be used to detail answers to questions on page 2 (If no information provided here: line through Section; or Attach additional pages if necessary): **PLEASE REFERENCE THE QUESTION NUMBERS IN YOUR RESPONSE BELOW.**

**SIGN AND DATE CERTIFICATION BELOW**

**CERTIFICATION**

I certify by entering my signature below, I am the person applying for licensure/certification/registration and I meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me and that statements made on the application are *true and complete*. I understand that providing false or misleading information as well as omitting information in response to information requested in this application or as part of the application process is considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

**Signature (Full Legal Name):**

**Date:**