Virginia Department of
Health Professions
Board of Nursing

9960 Mayland Drive
Suite 300
Perimeter Center
Henrico, Virginia 23233
(804) 367-4515
http://www.dhp.virginia.gov/Boards/Nursing/

CHECKLIST INSTRUCTIONS REINSTATEMENT OF 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 90-25-80 (B) if a nurse aide certificate has lapsed for more than ninety (90) days an application for reinstatement is required. To be eligible for reinstatement of a nurse-aide certificate, you must have performed nursing related activities within the two years preceding the expiration of your nurse aide certificate AND within two years of from the date the Board of Nursing receives your reinstatement application.

Additionally, **an individual who has previously had a finding of abuse, neglect or misappropriation of property is not eligible for reinstatement of his certification, except as provided in** 18VAC90-25-81

If you are unable to meet the specified work requirements, you are required by state/federal laws to re-take the nurse aide competency examination (skills and written) to determine competency for reinstatement of your nurse aide certification. If this requirement is applicable, you must provide evidence of re-taking and passing the required exam before your application for reinstatement will be considered complete.

Note: Applications and fees are retained for one (1) year only. If all requirements are not 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**.
☐	**Verification of performance of nursing related activities for compensation in the two (2) years prior to the expiration date of the nurse aide certification AND within two years of the Board's receipt of the application**: must meet this requirement to be eligible to reinstate a nurse aide certificate without having to re-take the nurse aide competency exam.

OR (If Applicable)

☐	**By checking this box, I understand that if after review of this application, the Board determines I do not meet the work requirements of nursing regulation 18 VAC 90-25-80 (B) I will be required to re-take the nurse aide competency exam (skills and written). The Board will notify you in writing regarding this determination and the required steps to follow in order to re-take the exam.**
☐	**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

Virginia Department of Health Professions
Board of Nursing

Nurse Aide Registry
9960 Mayland Drive, Suite 300
Perimeter Center
Henrico, Virginia 23233
(804) 367-4515
http://www.dhp.virginia.gov/Boards/Nursing/

APPLICATION FOR REINSTATEMENT 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 (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.

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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 4 below) and have certified copies sent directly from the court of any applicable court documents, Board Orders, etc. sent directly to the VBON.

Employment Verification: Below is a list of all the places where I have performed nursing-related duties for pay, including private-duty, **beginning with my most recent employer** and ending with the one I had two years **prior** to the expiration date of your certification. Included are the names of each employer/company, city/state the company or private-duty employment was in, my role or job held and the **month and year** I began each job, the **month and year** I ended each job. **Attach additional sheets to include all of the applicable employer information, if necessary**.

Employer Name (Current/Most Recent Employer First)	*City and State of Employer*	*Role or Job Held*	*Beginning Employment Date*	*Ending Employment Date*

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:**