State of California- Health and Human Services Agency

MAIL OR FAX APPLICATION TO:

California Department of Public Health (CDPH)
Licensing and Certification Division (L&C)
Healthcare Workforce Branch (HWB)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

CERTIFIED NURSE ASSISTANT (CNA)
INITIAL APPLICATION

(See instructions on the reverse)

SECTION I (REQUIRED)

TYPE OF REQUEST

◯ Check here if you are enrolling in a **CNA** training program **(complete sections I, II, III, IV, and V)**
◯ Check here if you are requesting **RECONSIDERATION** for a **previously revoked/denied** certificate **(complete sections I, II, III and V)**

SECTION II (REQUIRED)

Last Name	First Name	MI	Sex ◯ Male ◯ Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code
Confidential Address (Required)- (For CDPH Use only. If left blank all departmental mail will be sent to the address above)	*City*	*State*	*Zip Code*

Date of Birth	*Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)*	Driver's License /State ID Number
_____ *(mm/dd/yy)*	___ ___ ___ - ___ ___ - ___ ___ ___ ___ ***If you use an invalid SSN, your application process may be delayed*	*Number:* _____ *State:* _____

Phone Number ***

_____

☐ By checking this box, you agree to receive text messages from the California Department of Public Health (CDPH) for reminders and notifications regarding your application and/or certification. You may receive up to 5 messages per month. Message and data rates may apply. By checking this box, you agree to the Terms and Conditions and Privacy Policy. Reply "STOP" to opt-out, and "HELP" for help.

Email Address***

_____

SECTION III (REQUIRED)

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7).
   ○ Yes ○ No
   If yes, list conviction: _____
   Court of conviction: _____ Date: _____
2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
   ○ Yes ○ No
   Type of License/Certificate: _____
   License/Certificate Number: _____
   Type of Action: _____

SECTION IV (IF APPLICABLE)

Name of school or facility where you received/will receive the CNA training		Telephone Number	
Mailing Address (Number Street or P.O Box number	City	State	Zip Code
California Training Program ID Number for **CNA** (Required) CNA: _____	Beginning Date of Training _____ *(mm/dd/yy)*	End Date of Training _____ *(mm/dd/yy)*	

SECTION V (REQUIRED)

I certify under penalty and perjury under the applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application. I acknowledge that signing this document through electronic means shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.

_____ _____
Signature of Applicant Date

SECTION VI: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (only applies to students that have recently completed a CNA Training Program in CA.

		FOR VENDOR USE ONLY
_____ Printed Name	_____ Title	
_____ Signature	_____ Date	