TO: Applicant for Reinstatement of ADVANCED Nurse Aide Certification  
FROM: Cheryl Garland / C.N.A. Registry

Enclosed is an application for reinstatement of your ADVANCED nurse aide certification. If you hold an Advanced nurse aide certification, please complete this application and return to this office, along with a $30 check or money order made payable to the "Treasurer of Virginia", so that a decision can be made on whether you can be granted certification as an advanced certified nurse aide. Please note this fee is NONREFUNDABLE. In order to be eligible for reinstatement of ADVANCED nurse aide certification, you must also hold a current certification as a certified nurse aide.

If your certificate to practice as a certified nurse aide is not current, you will also need to submit a reinstatement application for that certification before your application for reinstatement of your advance certified nurse aide registration can be considered.

- Complete the front page in full, including name and current address. If your name is now different than that which is on your record, also include either a copy of your marriage certificate or legal document granting you the right to change your name.
- Mark a response to each of the screening questions at the top of the second page (questions 1-3). If you answer "Yes" to any of these questions, please see the explanation below*** as to what information you must submit concerning your conviction(s).
- Submit a letter on company letter signed by your supervisor confirming that you have provided the required three contact hours of continuing education for each of the years your certificate has been expired or an explanation of the reason you would like the Board to consider an extension or waiver of such continuing education requirements.

***If you have marked an affirmative answer to question 1, we will need the following information concerning your conviction: (1) a notarized statement that you have previously submitted such information to this office in order to either become certified or to reinstate your certificate in which you indicate the type(s) of conviction(s) you have received, when they were received, and when the Board approved the conviction(s), or (2) if this office has never received information concerning this affirmative response, then you will need to submit a certified copy of the court record showing the date and nature of the offense and the disposition of your case and that you have paid all fines and restitution. You can obtain the requested certified copy and proof of payment from the courthouse of the locality in which the conviction occurred. A police record obtained from the sheriff's office is not the same thing as a certified copy of the court record and cannot be accepted in place of the court copy. If the court also required any type of follow-up in regard to the disposition of your case, this office needs information from that source [a letter of compliance from your probation officer, counselors associated with community service programs or substance abuse treatment, discharge summary(ies) from substance abuse program(s), ASAP, etc.]. We also need you to send us a letter describing in detail the circumstances surrounding your conviction (generally answering the questions “who, what, why, where” in your letter will provide all of the information we need without our having to write back for a more complete explanation) and the steps you have taken to ensure it does not happen again. Then have someone (if possible a nursing-related employer) submit a letter of reference concerning your job performance and reliability. You can submit the application without this information; however, until we receive it, your application for advanced nurse aide certification cannot be considered.
I hereby make application for reinstatement of my advanced nurse aide certification in the Commonwealth of Virginia. The following information in support of my application is submitted.

PLEASE PROVIDE THE INFORMATION REQUESTED BELOW AND ON THE BACK OF THIS PAGE. PRINT OR TYPE. MAKE SURE YOU SIGN IT IN FRONT OF A NOTARY PUBLIC.

*Disclosure of Address: Some licensees have expressed concern that their residence address is accessible. Consistent with Virginia law and the mission of the Department of Health Professions, addresses of licensees are made available to the public. This has been the policy and practice of the Commonwealth for many years. However, the application of new technology makes such information more accessible. In most cases, it is permissible for an individual to provide an address of record other than a residence, such as a post office box or a practice location. Changes of address may be made at the time of renewal or at any time through written notification to the appropriate health regulatory board. Please be advised that all notices from the board, which include renewal notices, licenses, and other legal documents, will be mailed to the address provided.

**Disclosure of Social Security/Virginia DMV Number: When completing the application, you are required to submit your social security or a control number issued by the Virginia Department of Motor Vehicles (in accordance with Section 54.1-116 of the Code of Virginia). 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.

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<tr>
<th>Name – Last</th>
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<th>Middle</th>
<th>Maiden</th>
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* Current MAILING Address

<table>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone Number</th>
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Date of Birth

**Social Security or DMV Number

Virginia Advanced Nurse Aide Certificate Number

If your 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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RESPOND IN FULL TO THE FOLLOWING QUESTIONS, PROVIDING DOCUMENTATION REQUESTED. IF DOCUMENTATION WAS PREVIOUSLY SUBMITTED, PLEASE SO INDICATE WHEN.

___ YES ___ NO 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? If you answer “yes” to this question, you must submit the additional information regarding your conviction(s) as noted by asterisks (***).

___ YES ___ NO 2. Have you ever had action taken against or been denied a license or certificate in a health-related field.

Respond in full to the following questions. You may provide an explanation in “comments” section.

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).
4. 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:

EXPLANATION FOR REQUEST OF EXTENSION OR WAIVER OF CONTINUING EDUCATION HOURS:

CERTIFICATION

I CERTIFY BY ENTERING MY SIGNATURE BELOW: I AM THE PERSON APPLYING FOR CERTIFICATION AND MEET THE QUALIFICATIONS REQUIRED BY THE VIRGINIA BOARD OF NURSING

Further, I certify the information provided in this application has been personally provided and reviewed by me, and that the 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 are considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

Application Date: ______________________________________________________________

Signature (Full Legal Name): ______________________________________________________

☐ I AGREE TO THE ABOVE CERTIFICATION.