

Office of Professional Regulation
 Vermont Board of Nursing
Nursing Assistant Licensure by Examination

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| 2x2 Recent Photo- Paste Here Passport sized photo of head and shoulders taken within the last 6 months other than your driver's license or passport. | Application Fee: \$20.00 For Office Use Only |
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Directions:

Enclose a check or money order in the amount indicated, payable to "Office of the Secretary of State". **This application fee is non-refundable.**

All required documents for this application must be received by this office within 6 months of receipt. If application remains incomplete after 6 months it will be destroyed. If you are interested in reapplying, a new application and fee must be submitted.

You must complete each section of this form. Please print clearly.

Section A:

| | | | |
|--------------------------|---------|------------|----------|
| Name of Applicant: _____ | | | |
| (Last) | (First) | (Middle) | (Maiden) |
| Mailing address: _____ | | | |
| (Street & P.O. Box) | | | |
| _____ | | | |
| (City) | (State) | (Zip Code) | |

Note: It is unprofessional conduct for a licensee to fail to notify the Secretary of State's Office of a change of name or address within thirty (30) days (3 V.S.A. § 129a(a)(14)).

If your 911 address is different from your mailing address, please indicate the 911 address here:

| | |
|---|--|
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth (mm/dd/yyyy): _____ |
| Social Security # ____-____-_____ | Place of Birth (city, state, country): _____ |

*** Providing your social security number (SSN) is mandatory, and requested under the authority granted by 42 U.S.C. §405(c)(2)(C). It will be used by the Departments of Taxes, Child Support, Labor and the Judiciary in the administration of Vermont law, to identify individuals affected by such laws. Your SSN is not disclosed as part of a public records request.

| | |
|----------------------------|------------------------|
| Home Telephone: _() _____ | Cell Phone: _() _____ |
| Work Phone: _() _____ | E-Mail Address: _____ |

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Section B:

Please answer yes or no to each of these questions. If the answer is yes please follow the provided instructions.

| | | |
|--|-----|----|
| Have you ever committed acts of abuse, neglect, or misappropriation of patient property? <i>If "Yes", provide a detailed written explanation and attach all related documents.</i> | Yes | No |
| Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever denied your application for a license, certificate, or registration to practice a profession or occupation? <i>If "Yes", attach an official copy of the order or official notification of the action.</i> | Yes | No |
| Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) ever restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation? <i>If "Yes", provide an official copy of the order or official notification of the action.</i> | Yes | No |
| Have you ever surrendered a license, certificate, or registration to a licensing authority? <i>If "Yes", provide a detailed written explanation.</i> | Yes | No |
| Are you currently under investigation by another licensing authority? <i>If "Yes", provide a detailed written explanation and a copy of any available information from the licensing authority.</i> | Yes | No |
| Have you ever been convicted of a crime other than a minor traffic violation? (Note: Driving While Intoxicated and Driving Under the Influence are not "minor traffic violations.") <i>If "Yes", provide a detailed written explanation and attach the official certified court documents.</i> | Yes | No |
| Do you have any criminal charges pending against you in any jurisdiction (US or elsewhere)? <i>If "Yes", provide a detailed written explanation and attach a copy of the charging documents.</i> | Yes | No |
| Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice this profession with reasonable skill and safety? <i>If "Yes", please have your health care provider submit a detailed statement explaining how you are able to practice safely.</i> | Yes | No |
| Does your use of alcohol, drugs, or medications in any way impair or limit your ability to practice this profession with reasonable skill and safety? <i>If "Yes", provide a detailed written explanation.</i> | Yes | No |
| Are you currently addicted to or in any way dependent on, the use of alcohol or habit forming drugs? <i>If "Yes", provide a detailed written explanation.</i> | Yes | No |
| Are you currently participating in a supervised program or professional assistance program which monitors you in order to assure that you are not engaging in the use of alcohol or controlled substances? <i>If "Yes", please provide the contract/stipulation under which you are practicing.</i> | Yes | No |

Note: Vermont law requires that you report to the Office of Professional Regulation a felony conviction or any conviction of a crime related to the practice of your profession within 30 days (3 V.S.A. § 129a(a)(11)).

Note: Official documents must be certified.

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Section C:

CHILD SUPPORT:

Child Support Orders (15 V.S.A. § 795)

As of the date of this application: (you must check one)

I am not subject to a child support order; OR

I am subject to a child support order and am in good standing* or in full compliance with a plan to pay OR

I am not in good standing* or in full compliance with a plan to pay.**

TAXES:

Tax Compliance (32 V.S.A. § 3113(b)):

As of the date of this application: (you must check one)

I have never lived or worked in Vermont and do not owe Vermont taxes; OR

No taxes are due and payable and all required returns have been filed; OR

The liability for any taxes due and payable is on appeal; OR

I am in compliance with a payment plan approved by the Vermont Department of Taxes; OR

I am not in good standing* or in full compliance with a plan to pay.

UNEMPLOYMENT COMPENSATION:

Unemployment Compensation (21 V.S.A. §1378(b)):

As of the date of this application: (you must check one)

This does not apply to me because I have never been an employer in Vermont; OR

No contributions or payments in lieu of contributions are due and payable; or the liability for any contributions or payments in lieu of contributions due and payable is on appeal; or the employing unit is in compliance with a payment plan approved by the commissioner; OR

I am not in good standing* or in full compliance with a plan to pay.

DISTRICT COURT FINES / JUDICIAL BUREAU:

Unpaid Judgments (4 V.S.A. § 1110(c))

As of the date of this application: (you must check one)

I do not have any unpaid judgments; OR

I am in good standing* with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense; OR

I am not in good standing.*

* "Good standing" is defined in the statutes cited above. For more information, refer to the relevant statute specific to the particular question or consult the "Information for Applicants" on the OPR web page (www.vtprofessionals.org)

Section D:

Name of Nursing Assistant Program: _____

Street or P.O. Box: _____

City, State & Zip Code: _____ Telephone Number: (____) _____

Name of Program Administrator/Primary Instructor _____

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Section D Continued:

As of the date of this application, the highest level of education I have completed is:

High School Diploma GED Associate Degree Baccalaureate (4 yrs. of college)
 Graduate Degree (Masters/Doctorate) Did Not Complete High School
 Currently Enrolled in High School ***Please note this information is for Office use only.**

Section E: Required Enclosures – the following **must** be submitted for licensure:

- Completed Nursing Assistant Program Verification Form: This form must be completely filled out, signed, dated and enclosed in a sealed envelope by your nursing assistant program. This sealed envelope must be included with this application.
- A photocopy of your current driver's license, government issued ID or passport.

Section F: Temporary Permit

A temporary permit to practice as a LNA may be issued after verification of nursing assistant program completion. This permit remains valid pending receipt of the LNA examination results or 90 days, whichever comes first.

I am requesting a temporary permit to practice as a LNA. Yes No

I understand that my temporary permit to practice as a LNA allows me to practice only when supervised by a currently licensed Registered Nurse or Licensed Practical Nurse. Yes No

THE 90 DAY PERMIT CAN NOT BE EXTENDED.

Statement of Applicant

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application for licensure/certification/registration. (The maximum penalty for perjury is fifteen years in prison and/or a \$10,000 fine. 13 VSA §2901.)

Signature of Applicant: _____ Date: ___/___/_____

Please send completed application and fee to:
Attn: Board of Nursing
Office of Professional Regulation
National Life Building, North, Floor 2
Montpelier, VT 05620-3402

www.vtprofessionals.org/opr1/nurses

End of Application

Verification of Nursing Assistant Program

This form, completed and placed in a sealed envelope by an authorized administrator at the nursing assistant program, must be attached to the licensure application form, along with the fee. All required materials must be submitted together to the Board of Nursing office.

| | |
|---|------------------------------------|
| Name of Student/Applicant: _____ | DOB: ____/____/____ MM DD YYYY |
| I hereby authorize the nursing assistant program to furnish the information requested on this form and return it with my application to the Vermont Board of Nursing: | |
| Signature: _____ | Date: ____/____/____ MM DD YYYY |

| | | |
|--|---------|--------------------------|
| Name of nursing assistant program: _____ | | |
| Name of Program Administrator/Primary Instructor: _____ | | |
| Mailing address: _____ (Street/P.O. Box address) | | |
| _____ | _____ | _____ |
| (City) | (State) | (Zip Code) |
| I hereby verify that _____ was admitted into the nursing assistant program (Name of Applicant) | | |
| on ____/____/____ and completed the program requirements on ____/____/____. MM / DD / YYYY MM / DD / YYYY | | |
| This nursing assistant education program offers a course consisting of: | | |
| _____ | + | _____ |
| # of Classroom & Lab Hours | | # of Clinical Hours |
| | = | _____ |
| | | Total # of Program Hours |

| | |
|---|------------------------------------|
| Print Name: _____ | Date: ____/____/____ MM DD YYYY |
| Position/Title: _____ | |
| Telephone number: _(____)_____ | E-mail: _____ |
| Signature of Program Administrator/Primary Instructor _____ | |
| (Official Program Seal/Stamp) | |