NURSE AIDE COMPETENCY EVALUATION APPLICATION

State Form 43731 (R9 / 7-23)
INDIANA DEPARTMENT OF HEALTH – Consumer Services & Health Care Regulation

* This agency is requesting disclosure of your Social Security Number in accordance with 42 CFR 483.156(c)(1)(ii); disclosure is mandatory and this application cannot be processed without it.

SECTION I - APPLICANT INFORMATION

Name of applicant			Social Security Number *
Address *(number and street)*	City	State	ZIP code + 4
Telephone number ( )	E-mail address	County	
Date of birth *(month, day, year)*	Date of hire *(month, day, year)*		

SECTION II - COURSE INFORMATION (THIRTY (30) HOUR CLASSROOM EDUCATION)

Name of facility / school				Facility number
Address *(number and street)*	City	State	ZIP code + 4	County
Telephone number ( )	E-mail address	Date of classroom completion *(month, day, year)*		

I verify that the above named applicant has successfully completed at least thirty (30) hours of classroom instruction utilizing the Indiana Department of Health (IDOH) approved standards and resident care procedures and that a summary of all assessment tools and the RCP checklist are completed and available in this applicant's file.

Signature of program instructor	Date *(month, day, year)*
Printed name of program instructor	

SECTION III - COURSE INFORMATION (SEVENTY-FIVE (75) HOUR CLINICAL EDUCATION)

Name of facility				Facility number
Address *(number and street)*	City	State	ZIP code + 4	County
Telephone number ( )	E-mail address	Date of clinical completion *(month, day, year)*		

I verify that the above named applicant has successfully completed at least seventy-five (75) hours of clinical experience supervised by a licensed nurse utilizing Indiana Department of Health (IDOH) approved resident care procedures and that a summary of the RCP checklist are completed and available in this applicant's file.

Signature of clinical supervisor	Date *(month, day, year)*
Printed name of clinical supervisor	

APPLICANT VERIFICATION

I verify that the above information is correct.

Signature of applicant	Date *(month, day, year)*

SECTION IV - APPLICANT'S TEST STATUS

☐ Completed Indiana 105 hour Training

☐ Transferring From SLO

☐ Psychiatric Attendant

☐ Out of State CNA Verification

Name of state: ______________________

☐ Foreign Nurse

Country: ______________________________

☐ Student Nurse *(currently enrolled nursing student)*

School: ______________________________

☐ Graduate Nurse

Waiting to: ☐ Take Boards ☐ Retake Boards

☐ Other: ________________________________

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SECTION V – TEST / MONITOR INFORMATION

TEST NUMBER 1

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail

TEST NUMBER 2

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail

TEST NUMBER 3

Test entity		
Test monitor		
Test site		Date of test *(month, day, year)*
Written test ☐ Pass ☐ Fail	Oral test ☐ Pass ☐ Fail	Skills test ☐ Pass ☐ Fail