



The Equivalency Process

California Department of
Public Health



REQUIREMENTS

- ▲ Submit a completed Initial Application (CDPH 283 B)



- ▲ Complete the Live Scan fingerprint process in California by visiting a Live Scan Agency that provides fingerprinting services and submit the completed Request for Live Scan Service (BCIA 8016) form to our Department



REQUIREMENTS CONTINUED...

▲ You must submit an official, sealed transcript of training (students may substitute the official transcript with a sealed school letter on official school letterhead listing equivalent training in the Fundamentals of Nursing course). The letter must include the completion date(s), units/hours received, and grade obtained in the course. Copies of foreign transcripts are accepted.**



▲ **If degree was received more than two (2) years ago, please submit proof of work (paystub or W2) to show you have provided nursing or nursing related services in a facility to residents for compensation under the supervision of a licensed health professional within the last two (2) years.



INITIAL APPLICATION (CDPH 283 B)

You must complete an Initial Application (CDPH 283 B), indicating that you are applying for Equivalency. California's Initial Application (CDPH 283 B) is used for various processes; therefore, it is important to follow the sample on how to correctly complete the Initial Application (CDPH 283 B) for Equivalency.

(There is no fee to process your application)

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**CERTIFIED NURSE ASSISTANT (CNA)
AND/OR HOME HEALTH AIDE (HHA)
INITIAL APPLICATION**
(See instructions on the reverse)

THERE IS NO FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

Last Name		First Name		MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Number and Street or P.O. Box Number)			City	State	Zip Code
Date of Birth	Social Security Number (SSN)	Driver's License or State ID Number Number: _____ State: _____		Telephone Number	
Height	Weight	Hair Color		Eye Color	

*If you use an invalid SSN, your application will not be processed.

- 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
<input type="checkbox"/>	<input type="checkbox"/>

- 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
<input type="checkbox"/>	<input type="checkbox"/>

- If yes, indicate the type and number of license/certificate: _____

TYPE OF REQUEST (See A or B on the reverse.)

- Check here if you are enrolling in a CNA training program and complete the school portion below.
 Check here if you are enrolling in a HHA training program and complete the school portion below.

Name of School or Facility Where you Received / Will Receive the CNA or HHA Training			Telephone Number		
Mailing Address (Number and Street or P.O. Box Number)		City	State	Zip Code	
California Training Program ID Number(s) (Required)			Beginning Date of Training	End Date of Training	
Nurse Assistant: _____ Home Health Aide: _____					
<input type="checkbox"/> Check here if you have EQUIVALENT TRAINING . (See C on the reverse.) <input type="checkbox"/> Check here if you are requesting RECIPROCITY FROM ANOTHER STATE .			State: _____ (See D on the reverse.)		

NAME AND ADDRESS CHANGES: Certificate holders shall notify CDPH within sixty (60) days of any change of address. If you have had a name change, submit legal verification of the change (marriage certificate, divorce decree, or court documents). Failure to report a name or address change may result in the delay or loss of your certification.

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Signature of Applicant _____		Date _____	
TO BE COMPLETED BY THE REGISTERED NURSE (RN) 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 (this section only applies to students that have recently completed a CNA Training Program in California).		FOR VENDOR USE ONLY	
Printed Name _____	Title _____		
Signature _____	Date _____		

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SAMPLE

**CERTIFIED NURSE ASSISTANT (CNA)
 AND/OR HOME HEALTH AIDE (HHA)
 INITIAL APPLICATION**
 (See instructions on the reverse)

THERE IS NO FEE TO PROCESS THIS APPLICATION. YOUR APPLICATION WILL NOT BE PROCESSED IF ALL APPLICABLE QUESTIONS ARE NOT ANSWERED.

Last Name		First Name		M	Sex
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Number and Street or P.O. Box Number)			City	State	Zip Code
Date of Birth	Social Security Number (SSN)	Driver's License or State ID Number		Telephone Number	
		Number: _____ State: _____			
Height	Weight	Hair Color		Eye Color	

If you use an invalid SSN, your application will not be processed.

- 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
 - If yes, indicate the type and number of license/certificate: _____

TYPE OF REQUEST (See A or B on the reverse.)

- Check here if you are enrolling in a CNA training program and complete the school portion below.
- Check here if you are enrolling in a HHA training program and complete the school portion below.

Name of School or Facility Where you Received / Will Receive the CNA or HHA Training			Telephone Number		
Mailing Address (Number and Street or P.O. Box Number)		City	State	Zip Code	
California Training Program ID Number(s) (Required)			Beginning Date of Training	End Date of Training	
Nurse Assistant: _____		Home Health Aide: _____			
<input checked="" type="checkbox"/> Check here if you have EQUIVALENT TRAINING . (See C on the reverse.)			<input type="checkbox"/> Check here if you are requesting RECIPROCITY FROM ANOTHER STATE . State: _____ (See D on the reverse.)		

NAME AND ADDRESS CHANGES: Certificate holders shall notify CDPH within sixty (60) days of any change of address. If you have had a name change, submit legal verification of the change (marriage certificate, divorce decree, or court documents). Failure to report a name or address change may result in the delay or loss of your certification.

I certify, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Signature of Applicant _____	Date _____
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TO BE COMPLETED BY THE REGISTERED NURSE (RN) 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 (this section only applies to students that have recently completed a CNA Training Program in California).

Printed Name _____	Title _____
Signature _____	Date _____

FOR VENDOR USE ONLY

**INITIAL
 APPLICATION
 (CDPH 283 B)
 SAMPLE**

**You must complete all
 areas indicated in yellow**

OBTAINING YOUR FINGERPRINTS IN CALIFORNIA

You must obtain a criminal record clearance in order to receive a CNA certificate. You must complete the Live Scan fingerprint process **in California** by visiting a Live Scan Agency (Police Department, Sheriff Department, Fed Ex, USPS, We Print, Etc.).





REQUEST FOR LIVE SCAN SERVICE SAMPLE (BCIA 8016 SAMPLE)



SAMPLE FOR CERTIFICATION OF NURSE ASSISTANTS OR HOME HEALTH AIDES REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1226 **Certification**
 ORI (Code assigned by DOJ) Authorized Applicant Type

Certified Nurse Assistant (CNA) or Home Health Aide (HHA)
 Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:
California Department of Public Health (CDPH) **03314**
 Agency Authorized to Receive Criminal Record Information Mail Code (five-digit code assigned by DOJ.)
MS 3301, P.O. Box 997416 **(Leave blank)**
 Street Address or P.O. Box Contact Name (mandatory for all school submissions)
Sacramento **CA** **95899-7416** **(Leave blank)**
 City State Zip Code Contact Telephone Number

Applicant Information:

<p>Your last name</p> <p>Last Name _____</p> <p>Other Name Other last names known as</p> <p>(AKA or Alias) Last _____</p> <p>Date of Birth _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <table border="0" style="width: 100%;"> <tr> <td>Height _____</td> <td>Weight _____</td> <td>Color _____</td> <td>Color _____</td> </tr> <tr> <td>Height</td> <td>Weight</td> <td>Eye Color</td> <td>Hair Color</td> </tr> </table> <p>Place of Birth _____ <small>*Social Security Number (Required by CDPH)</small></p> <p>Place of Birth (State or Country) _____ Social Security Number _____</p> <p>Home Your mailing address</p> <p>Address Street Address or P.O. Box _____</p>	Height _____	Weight _____	Color _____	Color _____	Height	Weight	Eye Color	Hair Color	<p>Your first name & middle initial</p> <p>First Name _____ Middle Initial _____ Suffix _____</p> <p>Other first names known as</p> <p>First Name _____ Suffix _____</p> <p>California Driver's License Number</p> <p>Driver's License Number _____</p> <p>Billing Not Applicable</p> <p>Number (Agency Billing Number) _____</p> <p>Misc. Your telephone number</p> <p>Number (Other Identification Number) _____</p> <p>City _____ State _____ Zip Code _____</p> <p>Your Number: *Social Security Number (Required by CDPH) _____ Level of Service: <input checked="" type="checkbox"/> DOJ <input type="checkbox"/> FBI <small>CCA Number (Agency Identification Number)</small></p> <p>If re-submission, list ATI number: _____ Original ATI Number _____ (Must provide proof of Rejection)</p> <p>Employer (Additional response for agencies specified by statute): (Leave blank)</p> <p>Employer Name _____ Mail Code (five-digit code assigned by DOJ) _____</p> <p>Street Address or P.O. Box _____</p> <p>City _____ State _____ Zip Code _____ Telephone Number (optional) _____</p> <p>Live Scan Transaction Completed By:</p> <p>Name of Operator _____ Date _____</p> <p>Transmitting Agency _____ LSID _____ ATI Number _____ Amount Collected/Billed _____</p>
Height _____	Weight _____	Color _____	Color _____						
Height	Weight	Eye Color	Hair Color						

DEGREE

If you were or are presently enrolled in the Registered Nurse (RN), Vocational Nurse (VN) or Psychiatric Technician (PT) program, you must submit an official, sealed transcript of training (students may substitute the official transcript with a sealed school letter on official school letterhead listing equivalent training in the Fundamentals of Nursing course. The letter must include the completion date(s), units/hours received, and grade obtained in the course). Copies of foreign transcripts are accepted.



PROOF OF WORK

If degree was received more than two (2) years ago, you must submit proof of work (paystub or W2) to show you have provided nursing or nursing-related services in a facility to residents for compensation under the supervision of a licensed health professional within the last two (2) years.

CONTACT INFORMATION

Mailing Address:

California Department of Public Health
Aide and Technician Certification Section
MS 3301
P.O. BOX 997416
Sacramento, CA 95899-7416

Telephone Number:
(916) 327-2445

Fax Number:
(916) 552-8785

Website: www.cdph.ca.gov

Email: cna@cdph.ca.gov

CDPH WEBSITE INFORMATION



Helpful Links



Here is a link to the Initial Application (CDPH 283B):

<http://www.cdph.ca.gov/pubsforms/forms/CtrlIdForms/cdph283b.pdf>

Here is a link to the Request for Live Scan Service (BCIA 8016):

http://ag.ca.gov/fingerprints/forms/BCIA_8016.pdf

Here is a link to the Request for Live Scan Service Sample
(BCIA 8016 Sample):

[http://www.cdph.ca.gov/pubsforms/forms/CtrlIdForms/bcia8016sam
ple.pdf](http://www.cdph.ca.gov/pubsforms/forms/CtrlIdForms/bcia8016sample.pdf)