

# Transferring Your Out-of-State CNA Certificate to California (Reciprocity)

# 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



- ★ Submit a copy of your active Out-of-State Certified Nurse Assistant (CNA) certificate\*\*



# REQUIREMENTS CONTINUED...

- ★ \*\*If initial certification 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
- ★ Submit a completed Verification of Current Nurse Assistant Certification Form (CDPH 931), which is to be completed by the applicant and submitted to our office by the endorsing state agency



# INITIAL APPLICATION (CDPH 283 B)

You must complete an Initial Application (CDPH 283 B), indicating that you are trying to seek Reciprocity in California. 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 Reciprocity.

**(There is no fee to process your application)**

**CERTIFIED NURSE ASSISTANT (CNA)  
AND/OR HOME HEALTH AIDE (HHA)  
INITIAL APPLICATION**

*(See instructions on the reverse)*

MAIL OR FAX APPLICATION TO:  
California Department of Public Health (CDPH)  
Licensing and Certification Program (L&C)  
Aide and Technician Certification Section (ATCS)  
MS 3301, P.O. Box 997416  
Sacramento, CA 95899-7416  
PHONE: (916) 327-2445 FAX: (916) 552-8785  
EMAIL: cna@cdph.ca.gov

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

**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 enrolling in a **HHA** training program (complete sections I, II, III, IV, and V)
- Check here if you have **EQUIVALENT TRAINING** (complete sections I, II, III, and V)
- Check here if you are requesting **RECIPROCITY FROM ANOTHER STATE** (complete sections I, II, III, and V) Indicate State: \_\_\_\_\_

**SECTION II (REQUIRED)**

Last Name		First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (Number and Street or P.O. Box Number)		City	State	Zip Code
Date of Birth	*Social Security Number (SSN) <small>If you use an invalid SSN, your application process may be delayed.</small>	Driver's License or State ID Number Number: _____ State: _____	Telephone Number	
Height	Weight	Hair Color	Eye Color	

**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 11381.5 and 11381.7).
- 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: \_\_\_\_\_

**SECTION IV (IF APPLICABLE)**

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 for <b>CNA</b> (Required) or California Training Program ID Number for <b>HHA</b> (Required)		Beginning Date of CNA Training	End Date of CNA Training	
CNA: _____ HHA: _____		Beginning Date of HHA Training	End Date of HHA Training	

**SECTION V (REQUIRED)**

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

**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 (this section only applies to students that have recently completed a CNA Training Program in California).

**FOR VENDOR USE ONLY**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

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**SAMPLE****CERTIFIED NURSE ASSISTANT (CNA)  
AND/OR HOME HEALTH AIDE (HHA)  
INITIAL APPLICATION**  
(See instructions on the reverse)MAIL OR FAX APPLICATION TO:  
California Department of Public Health (CDPH)  
Licensing and Certification Program (L&C)  
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MS 3301, P.O. Box 997416  
Sacramento, CA 95899-7416  
PHONE: (916) 327-2445 FAX: (916) 552-8785  
EMAIL: cna@cdph.ca.gov

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

**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 enrolling in a HHA training program (complete sections I, II, III, IV, and V)
- Check here if you have **EQUIVALENT TRAINING** (complete sections I, II, III, and V)
- Check here if you are requesting **RECIPROCITY FROM ANOTHER STATE** (complete sections I, II, III, and V) Indicate State: \_\_\_\_\_

**SECTION II (REQUIRED)**

Last Name		First Name		MI	Sex
					<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing 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		

**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
- If yes, indicate the type and number of license/certificate: \_\_\_\_\_

**SECTION IV (IF APPLICABLE)**

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 for <b>CNA</b> (Required) or California Training Program ID Number for <b>HHA</b> (Required)		Beginning Date of CNA Training		End Date of CNA Training	
CNA: _____ HHA: _____		Beginning Date of HHA Training		End Date of HHA Training	

**SECTION V (REQUIRED)**

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

**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 (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 \_\_\_\_\_

**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.).

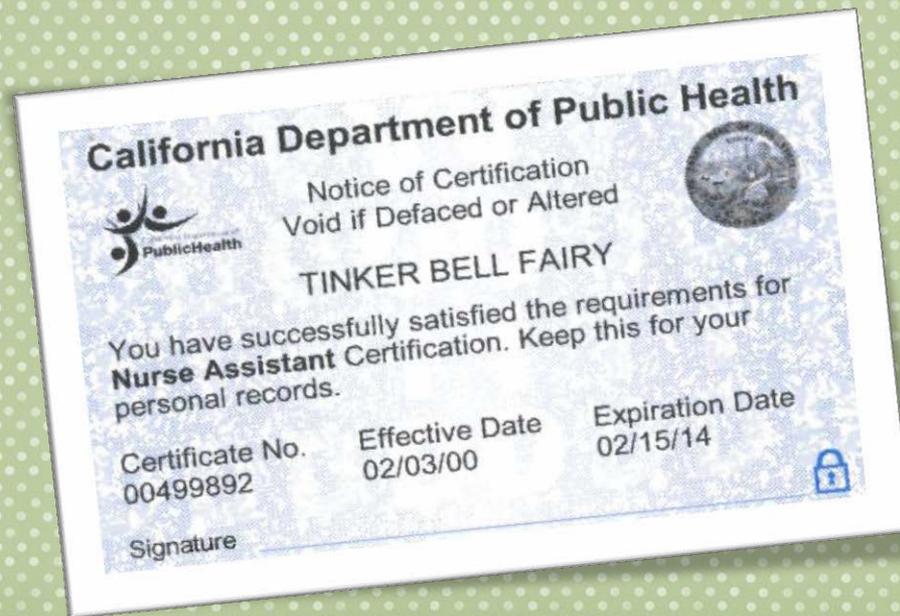






# OUT-OF-STATE CERTIFICATE

You must submit a copy of your Out-of-State CNA certificate as proof that you hold an active certificate in the state you wish to transfer from.

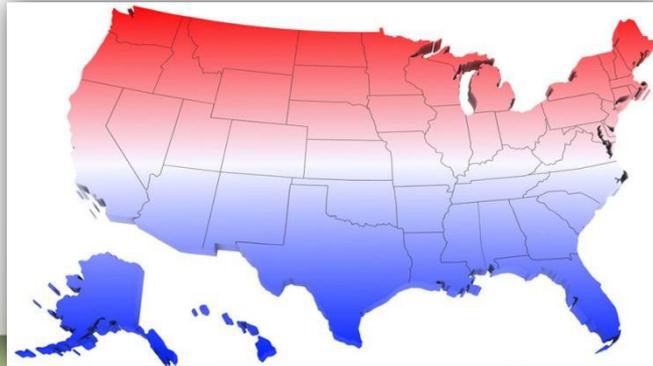


# PROOF OF WORK

If initial certification 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

# VERIFICATION OF CURRENT CERTIFICATION

In order to verify your Out-of-State certificate, you must complete the Verification of Current Nurse Assistant Certification (CDPH 931) Form. You will complete Part I of the form with your information, and then send the form to the state in which you currently hold the CNA certificate. Your endorsing state will complete Part II of the form and submit it to our department.



## VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

# VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION (CDPH 931) FORM

**PART I-To be completed by the applicant. Please PRINT clearly or TYPE.**

Last name:		First name:		MI:	
*Social Security Number:		Date of birth: (Month/Day/Year)		Telephone number: (     )	
Mailing address: (Number and Street Name or P.O. Box Number)			City	State	ZIP code
Originally certified under the last name of:			First	MI	
Original certificate number:		Original date of certification:		Date last provided certified nurse assistant duties:	

**PART II-Must be completed by state agency from which applicant holds active certification and must be mailed directly by Agency to CDPH. (See address above.)**

1. This individual is listed on the Nurse Aide Registry and has met all relevant Federal requirements pursuant to Title 42, Code of Federal Regulations (42 CFR), Sections 483.75, 483.150-483.156. Yes  No   
 Certification Number: \_\_\_\_\_ Expires: \_\_\_\_\_ Date of Issue: \_\_\_\_\_
2. Method of Certification (Check all that apply):  
 Certified by reciprocity from the state of: \_\_\_\_\_  
 Completed a state-approved training program of (specify number of hours): \_\_\_\_\_  
 Passed a state-administered competency evaluation (i.e. examination) on what date: (mm/dd/yy) \_\_\_\_\_  
 Not Available (please explain): \_\_\_\_\_
3. Is there documentation of substantiated abuse, neglect or misappropriation of resident property by this individual? Yes  No   
 (If yes, please attach explanation.)
4. Is there documentation of a felony conviction in a court of law? (If yes, please attach explanation.) Yes  No
5. Disciplinary Status:  None  Revoked  Denied  Suspension Yes  No

It is hereby certified that the above facts are stated from official records pertaining to this individual in the office of the undersigned.

\_\_\_\_\_  
 Date



Name \_\_\_\_\_ Title \_\_\_\_\_  
 Agency \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Telephone \_\_\_\_\_

**SAMPLE**

**VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION**

**PART I-To be completed by the applicant. Please PRINT clearly or TYPE.**

Last name:		First name:		MI:
*Social Security Number:		Date of birth: (Month/Day/Year)		Telephone number:
Mailing address: (Number and Street Name or P.O. Box Number)		City	State	ZIP code
Originally certified under the last name of:		First	MI	
Original certificate number:	Original date of certification:		Date last provided certified nurse assistant duties:	

**PART II-Must be completed by state agency from which applicant holds active certification and must be mailed directly by Agency to CDPH. (See address above.)**

- This individual is listed on the Nurse Aide Registry and has met all relevant Federal requirements pursuant to Title 42, Code of Federal Regulations (42 CFR), Sections 483.75, 483.150-483.156. Yes  No   
 Certification Number: \_\_\_\_\_ Expires: \_\_\_\_\_ Date of Issue: \_\_\_\_\_
- Method of Certification (Check all that apply):  
 Certified by reciprocity from the state of: \_\_\_\_\_  
 Completed a state-approved training program of (specify number of hours): \_\_\_\_\_  
 Passed a state-administered competency evaluation (i.e. examination) on what date: (mm/dd/yy) \_\_\_\_\_  
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It is hereby certified that the above facts are stated from official records pertaining to this individual in the office of the undersigned.

\_\_\_\_\_ Date

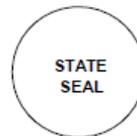
\_\_\_\_\_ Name \_\_\_\_\_ Title \_\_\_\_\_

\_\_\_\_\_ Agency \_\_\_\_\_

\_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_ Telephone \_\_\_\_\_



# VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION (CDPH 931) SAMPLE FORM

You must complete all areas indicated in yellow and submit the form to the state you wish to transfer from.

# 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](http://www.cdph.ca.gov)

## **Email:**

[cna@cdph.ca.gov](mailto:cna@cdph.ca.gov)

# CDPH WEBSITE INFORMATION



## Helpful Links



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

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

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

[http://ag.ca.gov/fingerprints/forms/BCIA\\_8016.pdf](http://ag.ca.gov/fingerprints/forms/BCIA_8016.pdf)

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

<http://www.cdph.ca.gov/pubsforms/forms/CtrlForms/bcia8016sample.pdf>

**Here is a link to the Verification of Current Nurse Assistant Certification (CDPH 931):**

<http://www.cdph.ca.gov/pubsforms/forms/CtrlForms/cdph931.pdf>