

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)

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).
 - If yes, list conviction: _____ Court of conviction: _____ Date: _____
 Yes No
- 2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
 - If yes, indicate the type and number of license/certificate: _____
 Yes No

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: _____			

- Check here if you have **EQUIVALENT TRAINING**. (See C on the reverse.)
 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

INITIAL APPLICATION (CDPH 283 B) SAMPLE

You must complete all areas indicated in yellow

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
 - 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: _____		

- Check here if you have **EQUIVALENT TRAINING**. (See C on the reverse.)
- 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).

FOR VENDOR USE ONLY

_____ Printed Name	_____ Title
_____ Signature	_____ Date

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 (BCIA 8016) FORM

You must complete all areas indicated in yellow. The Live Scan Agency will complete the bottom half (see example on next page).



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

CRI (Code assigned by DOJ)

Authorized Applicant type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - Assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City

State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name
(AKA or Alias)

First

Suffix

Date of Birth

Sex

Male

Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing
Number

(Agency Billing Number)

Place of birth (state or country)

Social Security Number

Misc.
Number

(Other identification Number)

Home
Address

Street Address or P.O. Box

City

State ZIP Code

Your Number:

OCA Number (Agency identifying Number)

Level of Service:

DOJ

FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSD

ATI Number

Amount Collected/Billed



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

Applicant Submission

A1226

ORI (Code assigned by DOJ)

Certification

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:

Your last name

Your first name & middle initial

Last Name

First Name

Middle Initial

Suffix

Other Name (AKA or Alias) Last **Other last names known as**

Other first names known as

Date of Birth

(Check one)

First Name

Suffix

Date of Birth

Sex: Male Female

California Driver's License Number

Height

Weight

Color

Color

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing **Not Applicable**

Place of Birth

*Social Security Number (Required by CDPH)

Number (Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. **Your telephone number**

Number (Other Identification Number)

Home **Your mailing address**

Address

Street Address or P.O. Box

City

State

Zip Code

Your Number: ***Social Security Number (Required by CDPH)**

OCA Number (Agency Identification Number)

Level of Service: DOJ FBI

If re-submission, list ATI number:

(Must provide proof of Rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)

Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City

State

Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

DC II 8016 (Rev. 07/06) SAMPLE

ORIGINAL - Live Scan Operator

SECOND COPY - Applicant

THIRD COPY (if needed) - Requesting Agency

NOTE TO APPLICANT: *Please input your Social Security Number (SSN) where required. The submission of your SSN will allow results to be transmitted from DOJ to CDPH accurately and timely. Failure to submit your SSN could cause delay in your certification.

**REQUEST
FOR LIVE
SCAN
SERVICE
SAMPLE
(BCIA 8016
SAMPLE)**

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.

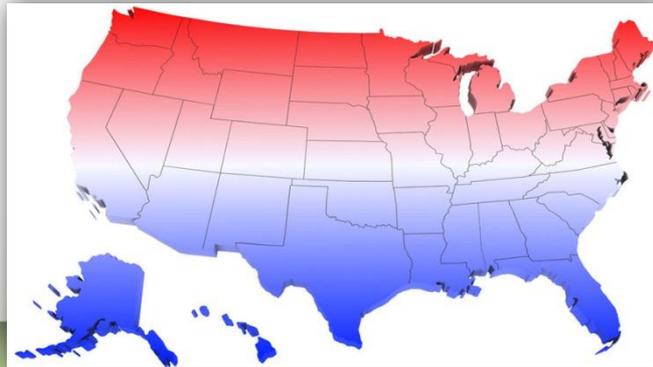


PROOF OF WORK

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 (CDPH 931) FORM

VERIFICATION OF CURRENT NURSE ASSISTANT CERTIFICATION

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

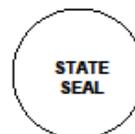
Last name:		First name:		MI:
*Social Security Number:	Date of birth: (Month/Day/Year)		Telephone number: ()	
Mailing address: (Number and Street Name or P.O. Box Number)		City	State	ZIP code
Originally certified under the last name of:		First	MI	
Original certificate number:	Original date of certification:	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) _____
 - Not Available (please explain): _____
- Is there documentation of substantiated abuse, neglect or misappropriation of resident property by this individual? Yes No
(If yes, please attach explanation.)
- Is there documentation of a felony conviction in a court of law? (If yes, please attach explanation.) Yes No
- Disciplinary Status: None Revoked Denied Suspension

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.

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

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.)

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 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): _____
- Is there documentation of substantiated abuse, neglect or misappropriation of resident property by this individual? (If yes, please attach explanation.) Yes No
- Is there documentation of a felony conviction in a court of law? (If yes, please attach explanation.) Yes No
- Disciplinary Status: None Revoked Denied Suspension

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 _____ Agency _____ Address _____ City _____ State _____ Zip Code _____ Telephone _____	Title _____
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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 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

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>