



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)

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 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: _____

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 CNA (Required) or California Training Program ID Number for HHA (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 _____

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INITIAL APPLICATION (CDPH 283 B) SAMPLE

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)
 Aide and Technician Certification Section (ATCS)
 MS 3301, P.O. Box 997416
 Sacramento, CA 95899-7416
 PHONE: (916) 327-2445 FAX: (916) 562-8785
 EMAIL: cna@cdph.ca.gov

THESE ARE THE FEES 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)

- 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: _____
- 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: _____

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 CNA (Required) or California Training Program ID Number for HHA (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
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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

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

Applicant Submission

ORI (Code assigned by DOJ) Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if 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) Last 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: _____ Level of Service: DOJ FBI
OCA Number (Agency Identifying Number)

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

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 LSID ATI Number Amount Collected/Billed

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).



**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 <u>OR</u> Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)			
Contributing Agency Information:		03314	
California Department of Public Health (CDPH)		Mail Code (five-digit code assigned by DOJ)	
Agency Authorized to Receive Criminal Record Information		(Leave blank)	
MS 3301, P.O. Box 997416		Contact Name (mandatory for all school submissions)	
Street Address or P.O. Box		(Leave blank)	
Sacramento	CA	95899-7416	Contact Telephone Number
City	State	Zip Code	
Applicant Information:			
Your last name		Your first name & middle initial	
Last Name	First Name	Middle Initial	Suffix
Other Name (AKA or Alias) Last		Other first names known as	
Date of Birth		First Name	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		California Driver's License Number	
Height	Weight	Color	Color
Height	Weight	Eye Color	Hair Color
Place of Birth	*Social Security Number (Required by CDPH)		
Place of Birth (State or Country)	Social Security Number		
Home Address		City	
Your mailing address		State	
Street Address or P.O. Box		Zip Code	
Your Number:	*Social Security Number (Required by CDPH)	Level of Service: <input checked="" type="checkbox"/> DOJ <input type="checkbox"/> FBI	
OCA Number (Agency Identification Number)			
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		Telephone Number (optional)	
State		Zip Code	
Live Scan Transaction Completed By:			
Name of Operator		Date	
Transmitting Agency		ATI Number	
LSID		Amount Collected/Billed	

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

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/bcia8016sample.pdf>