OKLAHOMA State Department of Health

Nurse Aide Registry (NAR)
PO Box 268816
Oklahoma City, OK 73126-8816
Tel. (405) 426-8150

Certified Nurse Aide Retest Application OAC 310:677-1-3(g)

Section 1 – Select the type(s) of Nurse Aide Certification(s) you are applying to retest for:

If you do not have at least 8 hours of work proof during the 24 month time frame of your certification (or at least 8 hours of work proof up to 24 months after your expiration date) and/or your certification has been expired more than two (2) years, but no more than three (3) years then you must retest. If you have been expired for three (3) years or longer you must retrain.

☐ **LTC – No Fee Required**	**Original Expiration Date:**_____
☐ **HHA – $15 Fee***	**Original Expiration Date:**_____
☐ **ICF/IID CA – $15 Fee***	**Original Expiration Date:**_____
☐ **RCA – $15 Fee***	**Original Expiration Date:**_____
☐ **ADC – $15 Fee***	**Original Expiration Date:**_____

Section 2 - Personal Information

_____/_____/_____ Date of Birth

_____/_____/_____ Social Security Number

First **MI** **Last**

If you have had a **name change since your last renewal, please include a certified copy of the marriage license or other court document which reflects the change of name when you submit this application.**

Current Mailing Address **City** **State** **Zip**

E-mail address **Telephone Number**

If this application is approved, you will receive an approval letter to take the written and skills exams at the testing facility of your choice. The original letter MUST be presented to the testing site before you will be authorized to take the examinations. Duplicate retest approval letter will not be reissued.

Upon completion of your test the testing entity has 30 days to submit testing results to the Nurse Aide Registry.
Upon receipt of your test scores, you will be added to the database.

If you have any questions, please call our office at **(405) 426-8150** or by email at **nar@health.ok.gov** .

Section 3 – Affirmation

I affirm the information on this form to be true and correct to the best of my knowledge.

X_____ ____/____/____ _____

Signature of Nurse Aide **Date** **Name of most recent employer – Phone Number**

LTC Retest Only – NO FEE required: Email: nar@health.ok.gov

Retest(s) requiring fee(s): Make check/money order payable to: **OSDH/Nurse Aide Registry**
Mail to: **NAR-OSDH, PO Box 268816, Oklahoma City, OK 73126-7599**

NOTE: *All fees submitted are Non-Refundable **Total Enclosed $**_____