

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.

- | | |
|--|---------------------------------|
| <input type="checkbox"/> LTC – No Fee Required | Original Expiration Date: _____ |
| <input type="checkbox"/> HHA – \$15 Fee** | Original Expiration Date: _____ |
| <input type="checkbox"/> DDCA – \$15 Fee** | Original Expiration Date: _____ |
| <input type="checkbox"/> RCA – \$15 Fee** | Original Expiration Date: _____ |
| <input type="checkbox"/> ADC – \$15 Fee** | Original Expiration Date: _____ |

****If requesting to retest for HHA, DDCA, RCA and/or ADCA a \$15 processing fee per certification is required. (OAC 310:677, 1-3(g))****

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, at which time you will be added to the database. You may verify your certification status online at nar.health.ok.gov****

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 Facility/Agency where employed – Phone

LTC Retest Only – NO FEE required: Email: nar@health.ok.gov
 Fax: (405) 900-7572
 Mail: 123 Robert S Kerr Ave, Suite 1702, Oklahoma City, OK 73102

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 73102**

NOTE: *All fees submitted are NON Refundable Total Enclosed \$ _____