

## Nurse Aide Renewal Application ALL SECTIONS MUST BE COMPLETED *IN FULL* FOR APPLICATION TO BE PROCESSED

Section 1 - Check	the type(s) of Nurse A	Aide Certification	n(s) you want t	o renew.
□ LTC – No Fee	□ <b>HHA -</b> \$10 Fee*	□ ICF/IIDCA - \$	10 Fee*	RCA - \$10 Fee*
□ <b>ADCA -</b> \$10 Fee*	☐ Feeding Assistant (I	<b>FA) -</b> \$10 Fee*		
Section 2 - Certified Medication Aide – Renewal				
□ <b>CMA -</b> \$10				
☐ Attach documentation of <b>continuing education</b> equivalent to <b>eight (8) hours</b> for every twelve months of certification, <b>excluding</b> the first year of certification.				
**Continuing Education Units (CEUs) must be completed during the certification period or within one year after that.				
***Advanced CMA certifications will be renewed at the same time as your CMA renewal. If you are requesting a <b>new</b> advanced CMA certification, please include the \$10 fee for each one requested with the Advanced Training Application received from the course instructor.				
Section 3 - Person	al Information			
		/_ Date of	_/ Rirth	// Social Security Number
		Date of	Direit	Godal Geodity Namber
First		MI		Last
If you have had a <u>name change</u> 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.				
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Current Mailing Addr	ess	City	State	Zip
E-mail address				Telephone Number
Section 4 – Employment Verification – Must submit proof of 8 hours paid work in nursing or nursing related services during the 24-month certification time frame.				
□Admini	strative Signature OR □	Paystub OR □Fo	orm W-2	Start Date End Date
				/ / - / / Aide is still employed: □Yes □ No
Facility Name				x
Address	City, State,	Zip Code Pho	one Number	Administrative/HR Signature
Section 5 – Affirmat	ion - I affirm the information	on on this form to b	e true and correct	to the best of my knowledge.
X		1 1		,
Signature of Nurse Aid	le	Date	Name of most re	cent Facility/Agency where employed – Phone
LTC Renewal only - NO Fee required: Email: nar@health.ok.gov, or Mail: NAR-OSDH, PO Box 268816, Oklahoma City, OK 73126-8816				
Renewal(s) Requiring Fee(s): Make check/money order payable to: OSDH/Nurse Aide Registry  Mail to: NAR-OSDH, P. O. Box 268816, Oklahoma City, OK 73126-8816				
NOTE: All Fees submit	ted are NON-Refundable			Total Enclosed \$