AMERICAN RED CROSS
Hawaii State Chapter
Contact the following phone numbers if you have a question in completing this form
(808) 734-2101, ext. 124 or 122,
or toll-free at 1-800-853-9991, ext. 124 or 122

State of Hawaii
Nurse Aide Registry
CNA Recertification

_____ Nurse Aide's certificate expires on _____. To work as a CNA you must keep your certificate current. **You are eligible for renewal, if you provide nursing or nursing-related service, direct patient care with compensation (for pay), for at least 7 hours in the 24 months since you were first certified or last recertified.** Please complete steps 1 and 2 below then give this form to your most current nurse aide employer of a licensed skilled nursing or intermediate care facility to complete steps 3 and 4 on the back of this page.

1. Please circle the correct answers and print clearly.

Hawaii Certificate # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Current Phone # (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Is this a change in phone #? YES NO

Current Name: _____ Is this a change of name? YES NO
Last, First MI (If yes, please submit copy of marriage/divorce)

Current Address: _____ Is this a change of address? YES NO
Street, PO Box

_____
City State Zip

2. Answer all questions by circling YES or NO.

1. In the past 20 years, have you ever been convicted of a crime for which the conviction has not been annulled or expunged? **YES NO**

2. Has your nurse aide certification ever been revoked, suspended or otherwise subject to disciplinary action by another state registry? **YES NO**

3. Are you presently being investigated or is any disciplinary action pending against you? **YES NO**

If you answered "YES" to any of the above questions, please explain below (Date, Place and Nature of Violation, etc.) _____

_____

4. Are you a - - (please check one of the following)
U.S. Citizen ____, U.S. National ____, or alien authorized to work in U.S. ____.

I hereby certify that the information supplied herein is true to the best of my knowledge. I understand that misrepresentation is grounds for revocation of this certification.

_____ _____
Signature of Certified Nurse Aide Date

Please give, or mail (do not fax), this form to your most recent long-term care nursing employer, who must complete the other side of this form and verify your work as a CNA.

(Revised 8//04)

To be completed by current or most recent employer. Fill in answer and checkmark Yes or No.

Name of Certified Nurse Assistant you are verifying for recertification: _____

3. Place of Eligible Nurse Aide Employment - Long-Term Care, Skilled Nursing or Intermediate Care Facility (/SNF ICF).

Name of Nursing Employment _____ Phone _____

Employment Address _____
Street, PO Box, RR City Island State Zip

Date of Hire: ___/___/____ Date of Termination (if applicable) ___/___/____

Is this facility or place of your CNA employment, recognized and licensed by the Dept. of Health, or the Dept. of Human Services?
Yes ___ No ___

Does the person verifying the nurse aide's employment have a professional license? Yes ___ No ___

If yes, what kind of license? _____ License # _____

4.Eligibility for Recertification

The individual named above has been compensated as a CNA for a minimum of seven (7) hours in the last 24 months for nurse aide work under the supervision of nursing personnel where there is a plan of care. Verification of employment must be signed by a licensed nurse, physician or a case manager responsible for the development of the plan of care and **cannot be self-endorsed**.

I certify that I have read, understand, and will comply with the policy set forth in the memorandum provided to me regarding my next recertification.

I certify that the information put forth in this recertification form is true and correct to the best of my knowledge.

Date: _____ Signature: _____ Phone #: _____

Type or print Name and your Title: _____ Title: _____
Signed by one of the following: DON, Staffing Coordinator, Case Mgr., Physician, RN, Eligible Employer (listed above in #3).

Mail completed form to: **American Red Cross,**
4155 Diamond Head Rd.
Hon., HI 96816,

For Red Cross use only:
Initial Certification Date ____/____/_____
New Expiration Date ____/____/_____
Date Registry Revised ____/____/_____

Revised 8/2004