



LOUISIANA RECIPROCITY FORM

THIS FORM SHALL BE MAILED, IT CANNOT BE FAXED. ORIGINAL SIGNATURES ARE REQUIRED.

If you have any questions, please contact the Nurse Aide Registry at (225) 342-0138.

Certified nurse aides (CNA) must complete the top part of this form. Attach a copy of your social security card and official Louisiana issued identification. If transferring from a state which uses online verification; mail this form and the information (above) to the address at the bottom of this page. If transferring from a state that does not use online verification, mail a reciprocity form to each state where you are currently certified. The bottom part of this form shall be completed by the registry, in each state, where you are currently certified.

Print Name: Last Name First Name Initial/Maiden Name

Present Address: P. O. Box / street/apt. city state zip code

Phone: () Social Security# - - Date of Birth / /

List each state where you are currently certified:

List each state where you were certified, but are no longer certified:

I have a finding of abuse, neglect or misappropriation on a Nurse Aide Registry in the state(s) of

I have a conviction on my record for abuse, neglect or misappropriation in the state(s) of

*****This form will not be processed if any of the items are blank.*****

By virtue of my signature (below), I attest that all information provided is true and correct to the best of my knowledge and is supportable by documentation. I understand that any falsified documents or information submitted to the Louisiana Nurse Aide Registry or the Department of Health and Hospitals will result in revocation of my certification and will also be forwarded to the Office of the Attorney General for possible prosecution. My signature also serves as authorization for other state registries to provide the information requested to the Louisiana Nurse Aide Registry.

Signature of Nurse Aide Date

NURSE AIDES - DO NOT WRITE BELOW THIS LINE

OUT-OF STATE NURSE AIDE REGISTRY STAFF COMPLETES THIS SECTION:

- 1. The individual listed above appears on our state registry for certified nurse aides: Yes ___ No ___ certification date ___/___/___ expiration date ___/___/___ certification number ___
2. This individual was placed on our registry via reciprocity from the state of ___
3. This individual completed one of our state approved training programs. Yes ___ No ___
4. This individual was granted "deemed" status for certification to the registry. Yes ___ No ___
5. This individual passed a state competency evaluation (both written and clinical). Yes ___ No ___
6. This individual has a finding of abuse, neglect or misappropriation on the registry. Yes ___ No ___
If yes, provide the date (___) the finding was placed and the documented reason the finding was placed.

Print Name of State Representative Title

Signature of State Representative State

Mail To: Louisiana Nurse Aide Registry P. O. Box 3767 Baton Rouge, La. 70821

STATE SEAL