

Applications that are incomplete or missing documentation will not be processed

Name (print) _____ Phone _____

Address _____ SSN _____

_____ Date of Birth _____

E-mail Address of Applicant _____

I am applying based upon my training as:

RN student/graduate LPN student/graduate military personnel Registered Nurse Licensed Practical Nurse

Students - Complete Section I

Nurses - Complete Section II

Military Personnel - Complete Section III

(Provide all documentation listed in the section completed. Official identification includes driver's license, state ID, military ID, etc.)

I. Name of School Attended _____

Address of School _____

Included: copy of social security card copy of official identification official transcript

II. Name of Licensing Board (if applicable) _____

Address of Board _____

Included: copy of social security card copy of official identification verification of current nursing license

III. Branch of Military where Trained (if applicable) _____

Medical Training Received: _____

Included: copy of social security card copy of official identification military transcript Form DD-214

NOTE: Any falsified documents submitted to this office will be forwarded to the Attorney General's Office for possible prosecution and your certification to the Louisiana Nurse Aide Registry will be revoked. All required information (completed application and attachments) shall be submitted to: LA.CNA@la.gov

OR

Nurse Aide Training Program Desk
P. O. Box 3767
Baton Rouge, La. 70821-3767

By virtue of my signature, I agree that the information provided is true and correct. I will abide by all state and federal regulations, as well as LA Department of Health policies and procedures. I understand it is my responsibility to notify the LA Department of Health, in writing, of any changes in the information provided at the time of application, and to report any changes in name, address, telephone number, or e-mail to the Louisiana Nurse Aide Registry once certified as a nurse aide. Failure to do so may result in loss of nurse aide certification.

Print Name of Applicant _____ Title _____

Signature of Applicant _____ Date _____