**KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES**

 Executive Order 20-56

 State of Disaster Emergency Related to Covid-19

 Temporary Certification Application

**Certified Nurse Aide, Certified Medication Aide**

* This application for temporary certification is specific to the State of Disaster of Emergency related to COVID-19 only. The temporary certification will be null and void immediately following the termination of the State of Disaster Emergency.
* Any person who was previously certified within Kansas and was in good standing prior to their lapse of the certification (within five years) may complete this application to apply for a temporary certification to work in an Adult Care Home facility. (**Please Note**: This application is only used to request a temporary certification. To renew a CNA certification, a Register Nurse (RN), can administer a skills/task checklist with an aide at a long-term care facility or hospital.)
* At the end of this temporary certification period, to continue to work in the state of Kansas, the applicant must meet the regulatory requirements for certification.

**Applicant Information:**

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI (maiden/surname)

**If change of name, please also attach a copy of your Driver’s License**

**Social Security Number** - - **Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

 MO Day Year

**Mailing Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip code

**Phone Number**: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EMAIL:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Method for Temporary Approval Notice:** (Please only select one method) \_\_\_**Mail** \_\_\_**Email**

**Certification Information:**

Kansas Credential Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select type(s) of temporary certification requesting.**

\_\_\_\_ Certified Nurse Aide/Assistant (CNA)

\_\_\_\_ Certified Medication Aide (CMA) (**also check CNA certification, if inactive**.)

**Candidate's Signature**

I do hereby attest that the information supplied in this application and any attachments is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application.

Candidate's Signature Date

**The completed form can be either be mailed or faxed or email to:**

**KDADS/Health Occupations Credentialing 785-296-3075 elizabeth.hernandez@ks.gov**

**503 S. Kansas Avenue**

**Topeka KS 66603-3856**

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| **KDADS USE ONLY**  Approval Date: Initials of approving staff member: |