KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES

**ALLIED HEALTH VERIFICATION**

for 90-hour Kansas Nurse Aide Certification

Complete this form and attach the following:

**** **Copy** of identification with current name & social security number (such as driver’s license and social security card)

**** **Application** fee of $20.00 (check or money order) **Or** completed KDADS Credit Card Form (attached)

**** **Nursing students**, a completed Documentation of Training signed by the nursing dept. (attached)

**** **An OFFICIAL** transcript from **current** training (must be currently attending nursing program) or a copy of professional license (if expired, must be within the last 24 months)

## All fees are NOT refundable Candidate Information

**Name:** \_ \_ \_ \_ First Middle Last Other names used

**Social Security Number:** - - **Birth date:** / / **Sex:** Male Female

**Address:** \_ \_ \_ Street

City State Zip Code **Phone Number:** Home ( ) Cell ( ) \_  **EMAIL: Preferred Method of Approval Letter:** \_**Mail Email**

## Check which applies (a suspended or revoked licensure will make you ineligible for the test):

|  |  |  |
| --- | --- | --- |
| Training |  | Licensure |
| RN  LPN  LMHT | OR | RN State  LPN State  LMHT State |

**Check Test Site Preference** (please only select one location)

Andover Concordia Hutchinson Lawrence Parsons Winfield

Atchison Dodge City Independence, KS Lenexa Pratt

Beloit Emporia Iola Liberal Salina

Burlingame Fort Scott Junction City Manhattan Topeka

Chanute Garden City KC KS Community College Merriam Wichita/Allied

Coffeyville Great Bend KC KS Delores Homes Olathe Wichita/Bethel

Colby Hays KC KS Donnelly Pittsburg Wichita/WSU Tech

## 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 and any attachments. *I have attached a* ***copy*** *of an identification document with my current name, social security number, and an official transcript or copy of professional license.*

\_ \_ \_ \_ \_ \_

Candidate's Signature Date

**Paying $20.00 fee by Check or Money Order: Paying $20.00 fee by Credit Card (Visa or MasterCard):**

|  |  |  |
| --- | --- | --- |
| Mail this form, fee, and all required attachments to: Health Occupations Credentialing, KDADS | **OR** | Email this form, credit card form, and all required attachments to: [kimberly.garrett@ks.gov](mailto:kimberly.garrett@ks.gov) |
| 503 S Kansas Topeka KS 66603-3865 |  |  |

KDADS USE ONLY: Approval Date Test Date

Candidate Information:

1. If a special accommodation is needed, you ***MUST*** submit the candidates Accommodation Request Evaluation Form with this application. The application can be accessed by clicking the following link: [https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/health- occupations-credentialing/certificattion-(cna-hha-cma)/certification-verification/forms/accommodation-request- form-(state-exam).pdf?sfvrsn=788005ee\_0](https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/health-occupations-credentialing/certificattion-(cna-hha-cma)/certification-verification/forms/accommodation-request-form-(state-exam).pdf?sfvrsn=788005ee_0)
2. If eligible, the candidate will receive an Approval to Test notice which will provide the preferred testing site contact information. The candidate will be responsible in contacting the testing site to schedule for a KS CNA exam.
3. The candidate must present the required identification, with one being picture I.D., to be admitted to test. The testing center will advise what types of identification will be required or allowed.
4. **CANDIDATE MUST BE ON TIME.** If the candidate is late, or fail to appear for their scheduled test, email Kim Garrett at [kimberly.garrett@ks.gov](mailto:kimberly.garrett@ks.gov) to request a rescheduling form which requires an additional fee of $20.00.
5. Nurse aide certificates are issued to those who achieve a score of at least seventy five percent (75%) on the nurse aide test. After 48hrs of receiving a passing score, a KS CNA certification will be available to view/print on the Kanas Nurse Aide Registry, [www.ksnurseaidregistry.org.](http://www.ksnurseaidregistry.org/)
6. The nurse aide test may be taken **only one time** based on training or licensure. Any candidate who fails the test on the first attempt **must enroll in a state-approved nurse aide training course.**
7. At the bottom of the Approval to Test notice, if qualified, will mention being allowed to work 4 months as a Trainee II from the approval date. **That date will not be extended.** This allows a nursing facility to employ you as a Nurse Aide Trainee II for a single four-month period beginning on the approval date
8. A candidate has one year from the Approval Date listed on the letter to sit for the exam, once. If a year has passed, and the candidate would still meet the qualification based on training or licensure, a required application, documentation, and fee will need to be resubmitted for consideration., If approved, this will allow for another year to be eligible to sit for the exam, once. Another Trainee II period will not be granted.

Web site: [www.kdads.ks.gov/hoc](http://www.kdads.ks.gov/hoc)

**DOCUMENTATION of TRAINING for challenging the Nurse Aide Test**: This form is to be used for nursing students who complete the topics listed below **and** have **clinical experience in geriatrics in the past 24 months** before they complete the semester nursing course(s). Please verify the individual has met the requirements, sign the attestation below and return this form along with the individual’s Allied Health Verification application, copy of applicant’s driver’s license, social security card, official transcripts, and fee to Health Occupations Credentialing.

# within the last **24 months** has successfully completed the topics listed below **and** clinical experience in geriatrics.

*Requirements/Required Topics*:

# Basic Skills

Communication and interpersonal skills Infection control

Safety/emergency procedures, including the Heimlich maneuver

Promoting resident independence Respecting resident rights

1. Basic Nursing Skills

Taking and recording vital signs Measuring and recording height and

weight

Caring for the resident environment Recognizing abnormal changes in body

functioning and the importance of reporting such changes to a supervisor

Caring for residents when death is imminent

1. Personal Care Skills Cleanliness and grooming Nutrition and fluids

Lifting and moving the resident Toileting

Skin care

1. Basic Restorative Services Safe use of mechanical devices

Normal range of motion and positioning Care and use of prosthetic and orthotic

devices

1. Mental health and social service needs Modifying aide=s behavior in response

to residents= behavior Awareness of developmental tasks

associated with the aging process

How to respond to resident behavior, using the resident=s family as a source of emotional support

1. Care of Cognitively Impaired Residents Communicating with cognitively

impaired residents

1. Clinical Experience in Geriatrics

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

Nursing Department Coordinator Name (Please print.) Signature

Telephone Number E-mail

School

|  |
| --- |
| **KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES** |
| **SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION** |
| **HEALTH OCCUPATIONS CREDENTIALING** |
| **CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD** |

This charge is for: **Please Print Facility Name for CRC OR Name of individual for Certification/Licensing**

As payment of fees for:

|  |  |
| --- | --- |
| Certification CNA/CMA/HHA/ALLIED NLY | |
| Course # |  |
|  | Certified Nurse Aide |
|  | Interstate |
|  | Certified Home Health Aide |
|  | Certified Medication Aide |
|  | CMA Renewal |
|  | Reschedule State Test |
| **x** | Allied |
| $ **20.00** | Fee amount paid |

|  |  |  |
| --- | --- | --- |
| Licensing - SLP, Audiology, Diet, Admin, Operator | | |
| Circle Type to Select |  | enter credential number if known or X if new |
| Temporary | Speech Language Pathologist |
| Initial/Full | Audiologist |
| Reciprocal | Dietitian |
| Renewal | Adult Care Home Administrator |
| Reinstatement | Operator Registration |
| $ | Fee amount paid |

***Credit Card company service fee of 3.04% will be added to the total***

|  |  |
| --- | --- |
| Criminal Record Check - Facility Use Only | |
| Number of names checked: |  |
| $10.00 per name | |
| Total Paid $ |  |

# VISA Card number (required) Expiration Date (required)

OR

MASTERCARD Number (required) Expiration Date (required)

Name of Cardholder (required) Signature (required)

|  |  |
| --- | --- |
| *wj* | *4.9.21* |

|  |  |  |
| --- | --- | --- |
| FOR OFFICE USE ONLY:  AMOUNT: SERVICE FEE: | | TOTAL CHARGED |
|  |  |  |