Nursing Assistant Registry Update Form

You are required by 42 CFR 483.156 to provide certain identifying information on this application such as certificate number, name, address, and telephone number. Your social security number will remain private. Your name and address are public information. The other identifying information, except for your social security number, will become public after you receive your certificate. If you do not supply adequate identifying information, you may not be eligible for placement on the registry.

**PLEASE ALLOW 30 BUSINESS DAYS FOR PROCESSING**

**Instructions:**
1. **Complete Section A and sign this form** at the bottom.
2. **Have your Employer complete Section B.**
3. **You must attach a copy of a recent paystub from the employer listed in Section B.** If you are not working in a nursing home or certified home health agency you will need to attach a copy of your job description from the employer listed in Section B.

**Note:** we will return your form unprocessed if the paystub and job description (if required) are not attached.

### Section A: Applicant Information

Certificate Number: __________________________

Social Security Number (SSN): __________________________

Legal Name (Last, First, Middle - No initials): __________________________

Current Mailing Address (include apt): __________________________

City, State, Zip Code: __________________________

Phone Number (include area code): __________________________

Email Address: __________________________

Name or SSN Change? __________________________

We will not process your name change unless you attach a photocopy of your marriage certificate, divorce decree or court order document. We will not process your social security number (SSN) change/correction unless you attach a photocopy of your social security card.

### Section B: Employment Information

To be filled out by the employer.

Provide the following information about your *past, present, or most recent employment in Minnesota* as a nursing assistant. If you worked for a staffing agency, Section B must be filled out by the nursing facility where you worked. *This form cannot be completed by the staffing agency.*

Do not verify employment until after this individual has worked 8 hours independently for your agency/facility.

Name of Facility/Home Health Agency: __________________________

Facility/Agency Phone Number (include area code): __________________________

Specify department/area this Nursing Assistant worked in: __________________________

Employment Start Date (Month/Day/Year): __________________________

Actual Last Working Date (Month/Day/Year/Current): __________________________

~ Administrator or DON completes the following information ~

By signing this, you are verifying that this individual, [circle one] *is* / was working at the above-named nursing facility/agency performing nursing assistant functions, and the employment dates above are correct.

Signature (Admin. or Director of Nursing) __________________________ Date __________________________

Signature (Nursing Assistant) __________________________ Date __________________________

Minnesota Department of Health
Minnesota Nursing Assistant Registry
PO Box 64501
St. Paul, MN 55164-0501

health.FPC-NAR@state.mn.us | 651-215-8705

To obtain this information in a different format, call: 651-215-8705.

04/15/20