GEORGIA DEPARTMENT OF COMMUNITY HEALTH

STATE OF GEORGIA
NURSE AIDE REGISTRY
NURSE AIDE CERTIFICATION RENEWAL

Dear Certified Nurse Aide:

In order to remain on the Registry and to be eligible to work in a licensed facility, you must meet the requirements for re-certification. Federal Regulations require that you must have worked as a CNA for pay, a minimum of eight hours within the last 24 consecutive months under the supervision of a Registered Nurse. If you are unable to meet this requirement, you must be **retest** to remain on the Georgia Registry. If your certification expires three or more years from date of last re-certification date, then you must take another State approved nurse aide training program.

You must send the Registry a completed *Application for Renewal as a Certified Nurse Aide*. The form is enclosed, but may be printed from the web site (www.mmis.georgia.gov) or you may request a form via the Interactive Voice Response System 678-527-3010 or 800-414-4358.

If you **are** currently working as a nurse aide, complete **Section A** of the application form and have your employer sign the form. **Submit a copy of check stub or W-2 Form as verification of employment. Private Duty requirements below apply to section A.**

If you **are** currently working or have worked private duty employee, please provide proof of income. Acceptable private duty services must be under the general supervision of a LPN/RN**. Please include a Notarized statement with detailed job duties and time frame worked from employer with LPN/RN signature and license number. Also, attach a copy of check stub or W-2 form as verification of employment. These requirements apply to section A and B. Failure to submit proof will delay your re-certification.**

If you **are not** currently working as a nurse aide, but meet the requirements of 8 hours of work within the last 24 consecutive months as a nurse aide, complete **Section B** of the application form. **Private Duty requirements above apply to section B.**

Please be sure to include your signature and the signature of your current employer, if applicable in the space provided. Please do not fax certification renewal forms to us. We must have the form with original signatures.

You will be issued a new certification card identifying the new two-year expiration date. If your name changes within the next 24, months fill out a Change of Name form and mail to the Georgia Medical Care Foundation, Attn: GA Nurse Aide Registry, P.O. Box 105753, Atlanta, Georgia 30348. You may print a request for *Change of Name* or C*hange of Personal Information* via the website (www.mmis.georgia.gov) or request a form via the Telephone Interactive Voice Response System by calling 678-527-3010 or 800-414-4358.

Failure to return the *Application for Renewal as a Certified Nurse Aide* will result in your name being removed from the Georgia Registry and you will not be eligible to be hired as a nurse aide by a licensed Medicaid facility. If you have any questions or need additional information, please call the numbers above. Thank you for your cooperation.

Sincerely,

Georgia Nurse Aide Registry

STATE OF GEORGIA
NURSE AIDE REGISTRY
APPLICATION FOR RENEWAL AS A CERTIFIED NURSE AIDE

(PLEASE PRINT)
Name:

_____
LAST FIRST MI

ADDRESS: _____
Street/Apt Number

_____
City State Zip Code County

SOCIAL SECURITY or CERTIFICATION NUMBER:_____
DATE OF BIRTH:_____
PHONE NUMBER:_____E-MAIL ADDRESS:_____

I certify that all the information on this form is true and complete.

_____ _____
SIGNATURE OF NURSE AIDE ***DATE***

Verification of Employment
Section A

If you **are** currently working as a CNA, please complete the information below with your employer's signature and a copy of a check stub or W-2 Form as proof of employment. **Acceptable Private Duty must be under the general supervision of a LPN/RN. Private Duty requirements must include a notarized statement with detailed job duties, signature of employer, signature of LPN/RN and license number, time frame worked and a copy of check stub or W-2 form as verification of employment.**

_____(_____)_____
Current Employer (Facility, Agency or Private Duty) Employer's Phone Number

_____
Employer's Address City State Zip Code Type of Employer

_____
Date Worked (From/To) **EMPLOYER SIGNATURE** Date

Section B

If you are NOT currently working as a CNA, please complete the information below for your most recent job within the prior 24 consecutive months as a nurse aide. **Please attach copy of a check stub, W-2 Form or letter from employer on letterhead as proof of employment. Acceptable Private Duty must be under the general supervision of a LPN/RN. Private Duty requirements must include a notarized statement with detailed job duties, signature of employer, signature of LPN/RN and license number, time frame worked and a copy of check stub or W-2 form as verification of employment.**

_____(_____)_____
Employer (Facility or Agency Name) Employer's Phone Number

_____
Employer's Address City State Zip Code Type of Employer

_____ _____
Date of Hire Date of End of Employment

Please return this form to: ***Georgia Medical Care Foundation***
PO Box 105753
Atlanta, GA 30348

Please allow 14 business days for processing.