



Oregon State Board of Nursing

17938 SW Upper Boones Ferry Road • Portland, OR 97224-7012
Phone: 971-673-0685 • Fax: 971-673-0684 • License Verification: 971-673-0679
E-mail: oregon.bn.info@state.or.us • Website: www.oregon.gov/OSBN

CNA 1 Endorsement Information

Certification Required

- You may not practice, sign your name as, or use a card, initials or device indicating you are a nursing assistant unless you hold a current certified nursing assistant card from the Oregon State Board of Nursing (OSBN).
- Practicing before you are certified is a violation of Oregon law and may result in a civil penalty up to \$5,000 under ORS 678.117.

Fee

Application	Fee	Explanation
CNAI Endorsement	\$60	For applicants to obtain Oregon CNAI certification who is trained and certified as a CNA in another state or jurisdiction.
Fingerprinting process	\$52	Required to obtain licensure or certification in order for the OSBN to conduct a national criminal history record check.

Endorsement Eligibility

Endorsement is the process that allows you to become a Certified Nursing Assistant I (CNAI) in Oregon based on training, certification, and CNA experience in another state.

You are eligible for CNAI Endorsement if you can document that you have:

- Completed a nurse aide training program that met OBRA standards; **and**
- Current CNA Certification in another state; **and**
- 400 or more hours of paid employment as a CNA in that state in the last two years (this requirement may be waived if you have graduated from a Nursing Assistant training program within the last two years); **and**
- Your paid employment as a CNA was under the supervision or monitoring of a licensed nurse.

Verification of Certification

Before submitting your CNAI Endorsement Application:

- 1) Contact the state where you are currently certified to:
 - Determine whether your certification is current or expired. If your certification is expired, you are not eligible for the endorsement process. Since fees are not refundable, check your certification status before submitting this application.
 - Inquire about the fee for written verification of your certification. Most states charge a fee for written verification.
- 2) Complete Section I (the top portion only), of the enclosed “Verification of Current CNA Certification” form.
 - Mail the “Verification of Current CNA Certification” form and fee to the state where you are currently certified. (See exceptions below) The state in which you are currently certified will complete Section 2 and return the completed verification form directly to the OSBN.

A list of CNA registries by state is available on the “Forms” page of the OSBN website.

Exception for Certificate Holders in Some States

If you are endorsing from **California, Colorado, Illinois, Indiana, Missouri, Nebraska or North Carolina**, please complete only Section I of the “Verification of Current CNA Certification” form and mail it along with the CNAI Endorsement application to the OSBN for processing – not your current state of certification. A verification is obtained by the OSBN for applicants endorsing from these states.



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CNA 1 Endorsement Checklist

Complete the application for CNAI Endorsement to Oregon.

- Answer all questions. An incomplete application will be returned.
- Type or print the information clearly to minimize delays and errors.
- Use the same name on the application and all forms.
- Provide written explanation of all YES responses. Use a separate sheet of paper for your written explanation(s). Provide dates, locations, actions taken, resolutions, and findings of written explanations.
- Sign and date the application.

Request verification from the state where you are currently certified to be sent to the OSBN.

- After you complete Section I of the "Verification of Current CNA Certification" form, mail it to your current state of CNA certification. (See exception in application information for California, Colorado, Illinois, Indiana, Missouri, Nebraska and North Carolina)

Mail the following to the Oregon State Board of Nursing (OSBN):

- Completed Fingerprinting documents** in a separate envelope, sealed by the fingerprinting facility. Contact the OSBN by sending an email to osbn.fingerprintinginfo@state.or.us, or call 971-673-0685 for more information or to obtain a fingerprinting packet.
- Completed CNAI Endorsement application.**
- Copy of your certificate of training completion** from the Nursing Assistant training program.
- Completed Nursing Assistant Work History Form.**
- Non-refundable application fee and fingerprinting process fee** by check or money order, payable to the Oregon State Board of Nursing.



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Licensure / Certification General Information

PLEASE NOTE

If you held an Oregon nursing license / certificate in the past, call the Oregon State Board of Nursing (OSBN) office and ask for information about Reactivation.

APPLICATION

- Apply for licensure/certification well in advance of employment in Oregon. In some cases, it can take several weeks for information from schools and other agencies to arrive for processing. If you meet the requirements for licensure/certification, your license will be issued approximately five business days after we have reviewed all of the required information and have determined eligibility.
- The OSBN may deny licensure/certification to an applicant convicted of certain crimes. If you have a criminal history, you will need to report it on your application and attach explanatory information on a separate sheet of paper. Falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of licensure/certification. A positive criminal record check will require investigation and may delay processing. Practicing before you are licensed/certified may result in a civil penalty.
- Your license/certification will be issued using the name on the initial application. If you change your name before issue, submit legal documentation of your name change and changes will be made before mailing your license/certificate. If your name has changed after issue, please contact the Board and request a duplicate license/certificate application.
- Your mailing address must be complete and current in order for your license/certificate to reach you promptly.

FEES

- Fees are non-refundable and processed on receipt. Even if you do not complete the application process or do not qualify for licensure/certification, the fee is not refundable. The fee pays for processing the application and, if you are eligible, issuing the license/certificate.
- A canceled check is your receipt and notification that the OSBN has received the application.

RENEWAL

- Oregon uses a biennial birth date renewal system. When you receive your license/certificate, please note the expiration date. The expiration date is the midnight before your birthday in an odd year if you were born in an odd year or in an even year if you were born in an even year. Because of this, your first license/certificate may be valid anywhere from 60 days to two years and 59 days depending upon when you were born and when your application is complete. After that, if renewed on schedule, your license/certificate is good for two years.
- Your license is valid until the expiration date printed on it. There is no grace period permitting practice beyond this expiration date.
- You will renew all licenses/certificates simultaneously.
- Notify the OSBN in writing when you change your address to prevent delays in receiving your renewal notice. The post office does not routinely forward the Oregon State Board of Nursing mail.

ADDITIONAL INFORMATION

- Refusal to provide a Social Security Number (SSN) may result in denial of license/certification issuance or renewal. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only, unless you authorize other use. If any disciplinary action is taken against your license/certification, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Section 666 (a)(13).
- If you have a disability that requires special materials or assistance, please contact the OSBN office at 971-673-0685. If you are hearing impaired, you may reach the OSBN through Oregon Relay Service, at 1-800-735-2900.
- Information about nursing practice in Oregon can be found at the OSBN web site at **www.oregon.gov/OSBN**.
- Call the OSBN office 971-673-0685 if you need additional information.
- You may call the automated line, 971-673-0679, to see if your license/certificate has been issued.



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Verification of Current CNA Certification

SECTION 1 TO BE COMPLETED BY APPLICANT. THEN SEND TO THE STATE YOU ARE CURRENTLY CERTIFIED. MANY STATES CHARGE A FEE TO PROCESS THIS FORM.

Last Name (Please print)		First Name	Middle Name
All former names and aliases (If none, indicate NONE)		Area Code ()	Home Telephone <input type="checkbox"/> Unlisted
Current State Certification Number	Date of Birth	Social Security Number -- --	
Mailing Address	City	State	Zip Code
I hereby authorize the state for which I am certified, which is _____ to furnish the information requested below. (Current State)			
I also authorize my contact information to be updated. <input type="checkbox"/> YES <input type="checkbox"/> NO			
Signature of Applicant		Date Signed (mm/dd/yyyy)	

SECTION 2 TO BE COMPLETED BY THE BOARD OR REGISTRY STAFF, THEN MAILED DIRECTLY TO THE OREGON STATE BOARD OF NURSING.

Applicant licensed by:	<input type="checkbox"/> Exam	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Deeming
Status of certification:	<input type="checkbox"/> Current	<input type="checkbox"/> Non-Practicing	<input type="checkbox"/> Lapsed <input type="checkbox"/> Encumbered (Explain on back of form)
Certification Number: _____	Original issue date: _____	Expiration date: _____	
CNA Training Program: _____	Graduation date: _____		
Has the application met Federal OBRA 1987 requirements?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If certified by Examination, dates passed for :	Written Exam _____	Manual Exam _____	
Disciplinary Status:	<input type="checkbox"/> None	<input type="checkbox"/> Restricted	<input type="checkbox"/> Suspension <input type="checkbox"/> Denied
	<input type="checkbox"/> Probation	<input type="checkbox"/> Warning	<input type="checkbox"/> Revoked <input type="checkbox"/> Censure
Are there any substantial findings of abuse?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

Board Seal	I hereby certify that the above is true and correct as recorded in the files of this office.	
	Signature:	_____
	Title:	_____
		_____ State _____ Date



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CNA 1 Endorsement Application

Attach \$60 non-refundable fee with application

Please type or print clearly using **black ink** on front and back of application

Last Name

First Name

Middle Name

All former names and aliases (If none, indicate NONE)

Female

Male

Social Security Number

Date of Birth (mm/dd/yyyy)

Place of Birth

-- --

Mailing Address

City

State

Zip Code

Area Code Home Telephone Unlisted Email Address

()

High School: Diploma GED Did not complete Date Graduated: _____

Nursing Assistant Training Program Name (**Attach Copy of Training Certificate**)

Training Completion Date

1) Which US state are you currently working or have most recently worked as a certified CNA? _____

NOTICE: If your CNA certification is expired, you are not eligible for endorsement. Call the OSBN for instructions.

2) List all US states in which you have held a CNA certificate, RN or LPN license. _____

3) Have you ever been certified as a Nursing Assistant (CNAI) in Oregon? Yes No

4) How many hours did you work as a paid CNA during the last two years? _____

In the table below, indicate your work hours by calendar year for the most recent three years you have worked. Do not include hours you were on vacation, sick leave or leave of absence. For example, if you last worked in 2006 complete the following table for the years 2006, 2005 and 2004.

	Calendar Year Worked	Total Hours Worked	Nursing Certificate Used for Practice
1 st year (most recent)			
2 nd year			
3 rd year			

Optional: Asian/Pacific Islander African American Hispanic Native American Caucasian Other

If you answer YES to any of the questions below, provide a written explanation on a separate sheet.

1	Do you have a physical, mental or emotional condition that in any way impairs your ability to perform CNA duties with reasonable skill and safety?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
2	Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense either misdemeanor or felony, including driving under the influence, in any state? (The fact that a conviction has been pardoned, expunged (excluding juvenile record expungement), dismissed or that your civil rights have been restored does not mean that you answer this question "NO"; you would answer "YES" and give details on the charge).	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
3	Have you ever been investigated for any type of abuse in any state?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
4	Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
5	Are any disciplinary actions <u>pending</u> against your CNA certificate or nursing license in any state or US jurisdiction?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
6	Have any disciplinary <u>actions been taken</u> against your CNA certificate or nursing license in any state or US jurisdiction?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
7	Have you ever suffered any civil judgment for incompetence, negligence or malpractice concerning the practice of a health care professional?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
8	Do you use, or have you used in the last five years, chemical substance(s) in any way, which impairs or limits your ability to perform as a nursing assistant with reasonable skill and safety? "Chemical Substance" includes alcohol and drugs.	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
9	Are you currently engaged in the illegal use of controlled substances? (Illegal use of controlled substances means the use of controlled substances obtained illegally (e.g. heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider).	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
10	Have you ever been found in any civil, administrative or criminal proceeding to have: a) Possessed, used, prescribed for use or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or prescription drugs, violated any drug law or prescribed controlled substances for yourself? b) Committed any act involving dishonesty or corruption? c) Violated any state or federal law or rule regulating the practice of a health care profession?	a) <input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
		b) <input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
		c) <input type="checkbox"/> YES Explain	<input type="checkbox"/> NO
11	Have you ever had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state, federal or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?	<input type="checkbox"/> YES Explain	<input type="checkbox"/> NO

If you answered YES to any of the above questions, "Explain" on a separate sheet.

Refusal to provide a Social Security Number (SSN) may result in denial of license/certification issuance or renewal. This record of your SSN will be used for child support enforcement, tax administration purposes (including identification) and criminal background checks only, unless you authorize other use. If any disciplinary action is taken against your license/certification, your SSN will be reported to the federal Health Care Integrity and Protection Data Bank. Authority: ORS 25.785, ORS 305.385, USC Section 666 (a)(13).

I hereby certify that I have read this application. I also certify that the information provided on this application is true and correct and that I have personally completed this application. I am aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of license/certification. I am aware that the Oregon State Board of Nursing will conduct criminal records checks through the Oregon Law Enforcement Data System (LEDS) and the Federal Bureau of Investigation (FBI).

Applicant's Signature

Date of Signature



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Nursing Assistant Work History

Please type or print clearly using black ink on the front and back

- List your Nursing Assistant work history, for the most recent two years.
 - Complete a separate section for each nursing assistant position in the last or most recent two years.
 - **Make as many copies of this form as needed** to document your work history.
 - If you worked for a multi-state corporation, list location of your assignment(s), not the state where the corporate headquarters is located.
 - If you worked for a local agency, list name and address of agency.
 - If you did private duty, give the name and address of the registry or individual you worked for, and the name and address of the RN who supervised you.
- Mark here if you completed Nursing Assistant or Nurse Aide training within the last two years and do not have work history. Date you completed Nursing Assistant training (mm/dd/yyyy): _____

Last Name	First Name	Social Security Number -- --
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Most recent employer (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address	City	State	Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)		
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Paid Nursing Assistant Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Under Nurse supervision or monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held	Primary Duties (Describe briefly)		

Employer Name (If none, indicate NONE)		Area Code ()	Telephone Number
Employer Address	City	State	Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)		
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Paid Nursing Assistant Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Under Nurse supervision or monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)			
Position Held	Primary Duties (Describe briefly)		

Employer Name (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Nursing Assistant Work? <input type="checkbox"/> Yes <input type="checkbox"/> No Under Nurse supervision or monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties (Describe briefly)	

Employer Name (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Nursing Assistant Work? <input type="checkbox"/> Yes <input type="checkbox"/> No Under Nurse supervision or monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties (Describe briefly)	

Employer Name (If none, indicate NONE)	Area Code ()	Telephone Number
Employer Address	City	State Zip Code
Start Date (mm/dd/yyyy)	If no longer employed, End Date (mm/dd/yyyy)	
Still Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Paid Nursing Assistant Work? <input type="checkbox"/> Yes <input type="checkbox"/> No Under Nurse supervision or monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Full time or <input type="checkbox"/> Part Time (Less than 36 hours a week)		
Position Held	Primary Duties (Describe briefly)	

NOTES :
