LOUISIANA DEPARTMENT OF HEALTH
Health Standards Section

Nurse Aide Certification Approval to Test Application

Applications that are incomplete or missing documentation will not be processed

Name (print)_____ **Phone**_____

Address _____ **SSN** _____

_____ **Date of Birth** _____

Email Address of Applicant _____

Have you previously tested for the CNA Exam? Yes ☐ **No** ☐ **If so, when**_____

Which test provider do you plan to test with: Prometric ☐ **LCTCS** ☐

I am applying based upon my training as:

☐ RN student/graduate ☐ LPN student/graduate ☐ Military personnel ☐ Registered Nurse ☐ Licensed Practical Nurse

Students - Complete **Section I** **Nurses -** Complete **Section II** **Military Personnel** - Complete **Section III**

(Provide all documentation listed in the section completed. Official identification includes driver's license, state ID, military ID, etc.)

I. Name of School Attended _____

Address of School _____

Included: ☐ **copy of social security card** ☐ **copy of official identification** ☐ **official transcript**

II. Name of Licensing Board (if applicable)

Address of Board _____

Included: ☐ **copy of social security card** ☐ **copy of official identification** ☐ **verification of current nursing license**

III. Branch of Military where Trained (if applicable)

Medical Training Received: _____

Included: ☐ **copy of social security card** ☐ **copy of official identification** ☐ **military transcript** ☐ **Form DD-214**

NOTE: Any falsified documents submitted to this office will be forwarded to the Attorney General's Office for possible prosecution and your certification to the Louisiana Nurse Aide Registry will be revoked. All required information, which includes the completed application and attachments, shall be submitted to: **LA.CNA@la.gov** (preferred method) or

Nurse Aide Training Program Desk
P. O. Box 3767
Baton Rouge, La. 70821-3767

By signing in the space provided below, I agree that the information provided above is true and correct to the best of my knowledge. I will abide by all State and Federal laws and regulations, as well as all Louisiana Department of Health policies and procedures. I understand it is my responsibility to notify the Louisiana Department of Health, in writing, of any changes in the information that is provided herein above. I agree to report any and all changes in name, address, telephone number, and/or email to the Louisiana Nurse Aide Registry as soon as possible. Failure to do so may result in loss of nurse aide certification.

Print Name of Applicant_____ **Title** _____

Signature of Applicant _____ **Date** _____