EXAMPLE for Los Banos Campus

State of California- Health and Human Services Agency

Must be typed & print 2 copies

MAIL OR FAX APPLICATION TO:
California Department of Public Health (CDPH)
Licensing and Certification Division (L&C)
Healthcare Workforce Branch (HWB)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416
PHONE: (916) 327-2445 FAX: (916) 552-8785

CERTIFIED NURSE ASSISTANT (CNA)
INITIAL APPLICATION

(See instructions on the reverse)

SECTION I (REQUIRED)

TYPE OF REQUEST

(X) Check here if you are enrolling in a **CNA** training program **(complete sections I, II, III, IV, and V)**
( ) Check here if you are requesting **RECONSIDERATION** for a **previously revoked/denied** certificate **(complete sections I, II, III and V)**

SECTION II (REQUIRED)

Last Name	First Name	MI	Sex
Sample Person (Name entered must match name on ID/DL EXACTLY.)	Los Banos	B.	(X) Male ( ) Female

Public Address (Required) – *Subject to Public Records Act Request release**	City	State	Zip Code
1234 Los Banos St.	Any Town	CA	93635
Confidential Address (Required)- (For CDPH Use only. If left blank all departmental mail will be sent to the address above)	*City*	*State*	*Zip Code*

Date of Birth	*Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)*	Driver's License /State ID Number
02/29/00 *(mm/dd/yy)*	9 8 7 - 6 5 - 4 3 2 1 **If you use an invalid SSN, your application process may be delayed*	*Number:* A7654321 *State:* CA

Phone Number *** (209) 777-7777

Email Address***
losbanossampleperson@yahoo.com

[X] By checking this box, you agree to receive text messages from the California Department of Public Health (CDPH) for reminders and notifications regarding your application and/or certification. You may receive up to 5 messages per month. Message and data rates may apply. By checking this box, you agree to the Terms and Conditions and Privacy Policy. Reply "STOP" to opt-out, and "HELP" for help.

SECTION III (REQUIRED)

1) Have you been **CONVICTED**, at any time, of any crime, other than a minor traffic violation? (You need not disclose any marijuana-related offenses specified in the marijuana reform legislation and codified at the Health and Safety Code, Sections 11361.5 and 11361.7).
   ◉ Yes ○ No
   If yes, list conviction: _____
   Court of conviction: _____ Date: _____

2) Has any health-related licensing, certification or disciplinary authority taken adverse action (revoked, annulled, cancelled, suspended, etc.) against you?
   ○ Yes ○ No
   Type of License/Certificate: _____
   License/Certificate Number: _____
   Type of Action: _____

Check one box for each question.

IF yes, fill in the blanks.

SECTION IV (IF APPLICABLE)

Address must be filled in EXACTLY as shown below.

Name of school or facility where you received/will receive the CNA training			Telephone Number
Merced College - Los Banos Campus			(209)384-6000
Mailing Address (Number Street or P.O Box number)	City	State	Zip Code
22240 Highway 152	Los Banos	CA	93635
California Training Program ID Number for **CNA** (Required) CNA: LEAVE BLANK	Beginning Date of Training LEAVE BLANK (mm/dd/yy)		End Date of Training LEAVE BLANK (mm/dd/yy)

SECTION V (REQUIRED)

I certify under penalty and perjury under the applicable state and federal laws that the information contained in this application and supporting documents, is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this application. I acknowledge that signing this document through electronic means shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.

LEAVE BLANK
Signature of Applicant

LEAVE BLANK
Date

SECTION VI: TO BE COMPLETED BY THE REGISTERED NURSE RESPONSIBLE FOR THE GENERAL SUPERVISION OF THE TRAINING PROGRAM

I certify that this individual has successfully completed state and federal nurse assistant training requirements and is eligible to take the Competency Evaluation (only applies to students that have recently completed a CNA Training Program in CA.

LEAVE BLANK
Printed Name

LEAVE BLANK
Title

LEAVE BLANK
Signature

LEAVE BLANK
Date

FOR VENDOR USE ONLY

It is YOUR responsibility to enter your information correctly on this form.

You should double and triple-check all information before submitting.