



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF HEALTH FACILITY LICENSURE
AND CERTIFICATION
Long-Term Care Nursing Assistant Program

NURSING ASSISTANT REFRESHER COURSE COMPLETION FORM

Submit to Professional Healthcare Development, Inc (PHD) at the address listed below. Type the information requested.

_____ Name and Address of Facility or School _____ Program Approval # _____

SOCIAL SECURITY NUMBER DISCLOSURE: Disclosure of your social security number should only be made if obtained from you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary for the purpose of internal identification, and may be used to verify information on your application, (class admissions and completions, competency evaluation testing, re-registration and reciprocity applications, etc), to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you. In accordance to the 42CFR 483.156(c), failure to provide requested information may result in your application being returned, a delay in processing, or your name not being placed on the West Virginia Nursing Assistant Registry.

	Print Complete Name (First, Middle, Last)	Social Security # XXX-XX-XXX	Date of Birth (mm/dd/yyyy)	Telephone # (xxx) xxx-xxxx	Aware of Privacy Disclosure (Student's Signature)
1					
2					
3					
4					
5					
6					
7					

This form must be received within **30 days** following completion of the program. ***Primary Instructor certifies the above information to be true and correct to the best of their knowledge and that individuals listed above are *qualified* to take the refresher and their expiration date on the Nursing Assistant Registry (www.wvdhhr.org/ohflac) is less than five (5) years.**

Program Start Date: _____ Instructor(s): _____

Scheduled Completion Date: _____

Revised 11/2011