



**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**

Joe Manchin III
Governor

Patsy A. Hardy, FACHE, MSN, MBA
Cabinet Secretary

Completion of Nursing Assistant Training Program

Complete this form and return to the Nursing Assistant Program prior to sending applications to Professional Healthcare Development. This form must be received within 30-days following completion of the program. **This form must be typed or printed legibly.**

Name and Address of Facility or School

Program Approval #

	Name			Address						
	First	M.	Last	D.O.B.	Mailing Address	City	St	Zip	County	SS#
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Program Start Date: _____

Program Completion Date: _____

Signature of Primary Instructor: _____

Signature of Coordinator: _____

The Program Coordinator and the Instructor certify the above information to be true and correct to the best of their knowledge.
***** This form will not be accepted if a calendar and class roster has not been submitted prior to beginning the class. *****

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.

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