



***New Jersey Office of the Attorney General***

Division of Consumer Affairs

New Jersey Board of Nursing

124 Halsey Street, 6th Floor, P.O. Box 45010

Newark, New Jersey 07101

(973) 504-6430

[www.njconsumeraffairs.gov/nur/Pages/default.aspx](http://www.njconsumeraffairs.gov/nur/Pages/default.aspx)

**Reinstatement Applicant Checklist - Certified Homemaker-Home Health Aide**

Please place a check mark next to each category, sign and date this checklist when submitting with your application.

Name of Applicant: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_ Review instruction sheet

\_\_\_\_ Application for Reinstatement. Answer all questions where indicated. (pages 2, 3)

\_\_\_\_ Notarized Affidavit (page 4)

\_\_\_\_ Affidavit for Employer Verification (page 5)

\_\_\_\_ Employment Certification for the Reinstatement of a Lapsed Certification (pages 6, 7)

\_\_\_\_ All required fees are included along with a check or money order only (page 15)

ALL QUESTIONS MUST BE FILLED IN WITH THE APPROPRIATE ANSWER OR THE LETTERS N/A (NOT APPLICABLE). **DO NOT LEAVE ANY BLANK ANSWERS OR YOUR APPLICATION WILL BE RETURNED.**

I have completed all of the above items.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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**Instructions for Reinstatement of a  
Homemaker-Home Health Aide Certification**

Please read the following information carefully before completing the application for Homemaker-Home Health Aide (HHA) certification.

If you have previously taken the 76 hour training, please provide a copy of the letter of completion from the Training School or Facility that was sent to the Board.

1. Complete an application for HHA Reinstatement Certification. Answer ALL of the questions.
2. Sign the application in the presence of a notary public.
3. Attach a clear, full-face original passport photograph (2" x 2") of your head and shoulders taken within the past six months. Sign your name on the front of the picture. (Photocopies and selfies are not acceptable.)
4. If you are a naturalized U.S. citizen, please submit a copy of your U.S. passport or certificate of naturalization.
5. If you are a legal alien or have other immigration status, please submit your USCIS immigration documents. (Submit a copy of both the front and the back of your card.)
6. Submit a check or money order for your application and certification fees in the amount of either \$80.00 or \$50.00 made payable to the "New Jersey Board of Nursing"- see fee schedule at the end of the application.
7. Please notify the Board of any change of address or change in your contact information.



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Attach a clear, full-face passport-style photograph (2"x 2") of your head and shoulders, taken within the past six months, with your name printed on the back of the photo.

A photo is required with each application.

Do not use staples to attach the photo.

**Application for Reinstatement of a Homemaker-Home Health Aide Certificate**

**You may not practice in the State of New Jersey until your Homemaker-Home Health Aide Certificate is Reinstated.**

Please print in black or blue ink only. This application must be completed, notarized and returned to the New Jersey Board of Nursing with your reinstatement fee payable by check or money order. **The certification fee is refundable.** Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

**Complete the following information:**

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Telephone number(s) \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Date of Birth \_\_\_/\_\_\_/\_\_\_ / Certificate number \_\_\_\_\_  
Month Day Year

E-mail address \_\_\_\_\_

**Social Security Number**

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in denial/nonrenewal of licensure or certification.

\*Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7,60.8 and 60.9, the Board or Committee is required to obtain your Social Security number. Pursuant to these authorities, the Board or Committee is also obligated to provide your Social Security number to:

- a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;
- b. the Probation Division or any other agency responsible for child support enforcement, upon request; and
- c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

- U.S. citizen
- Alien lawfully admitted for permanent residence in U.S.
- Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

Student Loan

Are you in default in regard to any student loan obligation(s)?  Yes  No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

Child Support

Please certify, under penalty of perjury, the following:

- a. Do you currently have a child-support obligation?  Yes  No
  - (1) If "Yes," are you in arrears in payment of said obligation?  Yes  No
  - (2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months?  Yes  No
- b. Have you failed to provide any court-ordered health insurance coverage during the past six months?  Yes  No
- c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding?  Yes  No
- d. Are you the subject of a child-support-related arrest warrant?  Yes  No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

\_\_\_\_\_

Applicant's name (please print) Applicant's signature Date

Please answer ALL of the questions below as they apply to the period of time since you were last certified **or** for the period of time since you last applied for reinstatement.

- 1. Have you been convicted of a crime?  Yes  No
- 2. Are there any criminal charges against you now pending?  Yes  No  
(Parking or speeding violations do not require you to answer "Yes," but all other motor vehicle offenses must be disclosed.)
- 3. Has your professional license been revoked or suspended (whether active or stayed) by any licensing board?  Yes  No
- 4. Is any action now pending against your professional license or have you been permitted to surrender or otherwise relinquish your license to avoid inquiry, investigation or action by any state licensing board?  Yes  No

# AFFIDAVIT

Please identify any person other than the applicant who helped to prepare this form:

\_\_\_\_\_

Name (print)

Date

Signature

**This affidavit is to be executed by the applicant before a notary public:**

State of: \_\_\_\_\_

County of: \_\_\_\_\_

} *ss.*

I, \_\_\_\_\_, in making this application to the New Jersey Board of Nursing for certification or licensure under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the New Jersey Board of Nursing, swear (or affirm) that I am the applicant and that all information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board.

I further swear (or affirm) that I have read N.J.S.A. 45:11-23 et seq., together with the Rules and Regulations of the New Jersey Board of Nursing, N.J.A.C. 13:37, and fully understand that in receiving certification or licensure from the Board, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board.

Sworn and subscribed to before me this \_\_\_\_\_

day of \_\_\_\_\_, \_\_\_\_\_

Month

Year

\_\_\_\_\_  
Name of Notary Public (please print)

\_\_\_\_\_  
Signature of Notary Public



\_\_\_\_\_  
My Commission Expires

Official Use Only - Do Not Write Below The Line

Candidate number \_\_\_\_\_

Certificate number \_\_\_\_\_

**AFFIDAVIT FOR EMPLOYER VERIFICATION**

**This affidavit is to be executed by the prospective employer before a notary public:**

State of: \_\_\_\_\_ }  
County of: \_\_\_\_\_ } *SS.*

I verify that the applicant named in the preceding affidavit will be employed by the agency indicated below upon the applicant's recertification.

\_\_\_\_\_  
Name of agency or health care service firm

\_\_\_\_\_  
Street address                      City                      State                      ZIP code                      County

\_\_\_\_\_  
Name of Prospective Employer (please print)

\_\_\_\_\_  
Signature of Prospective Employer or Human Resource Representative

\_\_\_\_\_  
Date

Sworn and subscribed to before me this \_\_\_\_\_  
day of \_\_\_\_\_, \_\_\_\_\_  
Month                                      Year



\_\_\_\_\_  
Name of Notary Public (please print)

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
My Commission Expires



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**Employment Certification for the Reinstatement of a Lapsed Certification**

**Directions:** Please complete this certification. Have it notarized and return it to the New Jersey Board of Nursing. If you have had more than two employers, please add additional sheets of paper with the employment data. The Board may contact your employer(s) to verify your employment.

\_\_\_\_\_  
*First name Middle name Last name Maiden name*

\_\_\_\_\_  
*Present Street Address City State ZIP Code*

C.H.H.A. Certificate No. \_\_\_\_\_ .

**Employment Data: (For the past five (5) years in New Jersey or in any other jurisdiction.)**

1. \_\_\_\_\_  
*Name of employing agency or facility*

\_\_\_\_\_  
*Street address*

\_\_\_\_\_  
*City State ZIP Code*

\_\_\_\_\_  
*Job Title Employment Dates: From To*

\_\_\_\_\_  
*Supervisor's name Title Telephone No. (include area code)*

2.

\_\_\_\_\_  
*Name of employing agency or facility*

\_\_\_\_\_  
*Street address*

\_\_\_\_\_  
*City State ZIP Code*

\_\_\_\_\_  
*Job Title Employment Dates: From To*

\_\_\_\_\_  
*Supervisor's name Title Telephone No. (include area code)*

*The person whose signature appears below personally appeared before me and, being duly sworn, says that he/she is the person referred to in the foregoing Employment Certification. The home health aide further attests that he/she has read and understands this certification and that all of the information contained herein is provided completely and truthfully to the best of his/her knowledge and beliefs.*

\_\_\_\_\_  
*Signature of applicant*

Sworn and subscribed to before me this \_\_\_\_\_

day of \_\_\_\_\_, \_\_\_\_\_  
*Month Year*

\_\_\_\_\_  
*Name of Notary Public (please print)*

\_\_\_\_\_  
*Signature of Notary Public*



\_\_\_\_\_  
*My Commission Expires*





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**Homemaker-Home Health Aide**  
**Reinstatement Application Fee Schedule**

	<b>Original License Issued In An Odd-Numbered Year</b>	
<b>Type of Fee</b>	<b>If your license expired before: November 30, 2017</b>	<b>If your license expired on or after: November 30, 2017</b>
<b>Current 2-year renewal fee</b>	<b>\$ 30.00</b>	<b>\$ 30.00</b>
<b>Previous 2-year renewal fee</b>	<b>\$ 30.00</b>	<b>0</b>
<b>Reinstatement fee</b>	<b>\$ 20.00</b>	<b>\$ 20.00</b>
<b>Total</b>	<b>\$ 80.00</b>	<b>\$ 50.00</b>