



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

Reactivation 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 Reactivation. Answer all questions where indicated. (pages 2, 3)

____ Notarized Affidavit (page 4)

____ Affidavit for Employer Verification (page 5)

____ Employment Certification for the Reactivation of an Inactive Certification (pages 6, 7)

____ All required fees are included along with a check or money order only (page 8)

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 Reactivation of an Inactive Certified
Homemaker-Home Health Aide Certification**

In accordance with the Uniform Enforcement Act, a professional or occupational license or certificate of registration may be reactivated, provided that the applicant otherwise qualifies for licensure, registration or certification, and complies with the provisions of N.J.S.A. 45:1-7.2 a, b, c and d. The necessary licensure reactivation application and materials may be downloaded from the Board of Nursing's website and include the following. Note: If your certification has been inactive for more than two (2) years, a reinstatement application must be utilized.

1. Reactivation Application:

Complete the enclosed application, attach a current passport photograph to the application, have the application notarized, and return it to the address indicated below.

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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 Reactivation of a New Jersey Homemaker-Home Health Aide Certificate

You may not practice in the State of New Jersey until your Homemaker-Home Health Aide Certificate has been Reactivated.

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 reactivation 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) _____ (Cell Phone)

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.

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 Reactivation of a Inactive 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
Reactivation Application Fee Schedule

(1) Payment of Biennial License Renewal Fee	-	\$ 30.00
(2) Reactivation Fee	-	\$ 20.00
<hr/>		
	Total	- \$ 50.00