



***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/nursing](http://www.NJConsumerAffairs.gov/nursing)

**Instructions for Reactivation of an Inactive H.H.H.A. Certificate**

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:

**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.**

**New Jersey Board of Nursing  
P.O. Box 45010  
Newark, NJ 07101**

**2. Application Packet:**

**Application Fees:**

- (1) Payment of the current biennial license renewal fee (\$30.00) (N.J.A.C. 13:37-5.5 (b)6).
- (2) Payment of \$20.00 application fee. (N.J.A.C. 13:37-5.5 (b)8).

**Affidavit for Employer Verification**

Attach a clear, full-face pass-  
port-style photograph (2"x2") of  
your head and shoulders, taken  
within the past six months,  
with your name signed on the  
bottom front of the photo.

A photo is required with each  
application.

Do not use staples to attach  
the photo



**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/nursing](http://www.NJConsumerAffairs.gov/nursing)

**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.**

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: \_\_\_\_\_ Cell Phone number: \_\_\_\_\_  
(Include area code) (Include area code)

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Year of Last Renewal: \_\_\_\_\_  
Month Day Year

If you are a U.S. - born citizen, please submit your birth certificate. If you are a foreign-born/naturalized U.S. citizen, please submit your birth certificate (English translation, if applicable) AND a U.S. passport OR certificate of naturalization.

E-mail address: \_\_\_\_\_ Certificate number \_\_\_\_\_

**Social Security Number**

You **must** provide your Social Security number to the Board or Committee. Failure to do so will result in a denial of your request for reactivation of your 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 certification reactivation. 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

### Criminal History and License History

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 reactivation.

- 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

## Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

For the purposes of these questions, the following phrases or words have the following meanings:

**“Ability to practice as a certified homemaker-home health aide”** is to be construed to include all of the following:

- The cognitive capacity to exercise reasonable homemaker-home health care judgments and to learn and keep abreast of professional developments; and
- The ability to communicate those judgments and related information to patients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and
- The physical capability to perform the duties of a homemaker-home health aide, with or without the use of aids or devices, such as corrective lenses or hearing aids.

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

**“Chemical substance”** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

**“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one’s functioning as a licensee, or within the previous two years.

**“Illegal use of controlled dangerous substance”** means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?  Yes  No
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program\*\*?  Yes  No  Not applicable
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice?  Yes  No  Not applicable
- Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety?  Yes  No  Not applicable
- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?  Yes  No
- Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that “currently” is defined as “within the last two years.”)  Yes  No

If you answered “Yes” to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?  Yes  No

\*\* If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for reactivation of licensure.



**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/nursing](http://www.NJConsumerAffairs.gov/nursing)

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 application. The person 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

**Affix Seal Here**

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

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

\_\_\_\_\_  
Date Commission Expires



**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/nursing](http://www.NJConsumerAffairs.gov/nursing)

**CERTIFICATION & AUTHORIZATION FORM  
FOR CRIMINAL HISTORY BACKGROUND CHECK**

Directions: Answer each question, sign and have the form notarized.

Mr.  
Mrs.

1. Name Ms. \_\_\_\_\_  
First Middle Last Maiden Name

2. Address \_\_\_\_\_  
Street City State ZIP code County

2a. C.H.H.A. number (if already issued) 26N \_\_\_\_\_

3. Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex:  Male  Female Place of Birth \_\_\_\_\_  
Month Day Year City State

4. Check Race:  Asian  Black  American Indian  Unknown  White

5. Social Security number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Telephone number \_\_\_\_\_  
Include area code

(Provision of your Social Security number is necessary to ensure the reliability of the background check.)

6. Employer name (N.J. home care services agency) \_\_\_\_\_

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

Identification number\* \_\_\_\_\_ Telephone number \_\_\_\_\_  
Include area code

\* Identification number refers to agency H.I.P. number, or facility number.

**CRIMES AND OFFENSES**

A person shall be disqualified from certification if that person's criminal history record background check reveals a record for conviction of any of the following crimes or offenses. (If you are not sure which crimes are considered disqualifying offenses, please check pages 3-5 of the instructions.)

- (1) In New Jersey, any crime or disorderly persons offense:
  - (a) involving danger to the person, meaning those crimes and disorderly persons offenses set forth in N.J.S.2C:11-1 et seq.; N.J.S.2C:12-1 et seq., N.J.S.2C:13-1 et seq., N.J.S.2C:14-1 et seq., or N.J.S.2C:15-1 et seq.; or
  - (b) against the family, children, or incompetents, meaning those crimes and disorderly persons offenses set forth in N.J.S.2C:24-1 et seq.; or
  - (c) involving theft as set forth in N.J.S.2C:20-1 et seq.; or
  - (d) involving any controlled dangerous substance or controlled substance analog as set forth in Chapter 35 of Title 2C of the New Jersey Statutes except paragraph (4) of subsection a of N.J.S.2C:35-10.
- (2) In any other state or jurisdiction, of conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described in paragraph (1) of this subsection.

7. Check **only one** box:

- I have **no record of conviction** for **any** of the disqualifying crimes or offenses identified on the previous page.
- I have been convicted of one or more of the disqualifying crimes or offenses identified on the previous page.

**Every such conviction on record must be disclosed.** True copies of each judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in automatic termination of your current employment, denial of an initial or reinstatement application as a homemaker-home health aide, revocation of certification or conditional certification and/or a fine of up to \$1,000.**

**Your continuing responsibility to disclose convictions of disqualifying crimes/offenses:** You **must** notify the New Jersey Board of Nursing within no more than five (5) business days if you are convicted of any of the disqualifying crimes or offenses identified on the previous page after this form has left your hands. Failure to do so may result in **automatic termination of your current employment, denial of an initial or reinstatement application for certification, revocation of your certification or conditional certification as a homemaker-home health aide and/or a fine of up to \$1,000.**

**You must immediately inform the New Jersey Board of Nursing in writing of any address change. A name change requires the submission of legal documentation.**

**AFFIDAVIT**

**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 reinstatement 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. 13:37-1.1 et seq., 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.

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

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

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

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





**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/nursing](http://www.NJConsumerAffairs.gov/nursing)

**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 \_\_\_\_\_ 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

\_\_\_\_\_  
Date

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

Day of \_\_\_\_\_, \_\_\_\_\_  
Month                      Year

**Affix Seal Here**

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

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

\_\_\_\_\_  
Date Commission Expires





**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/nursing](http://www.NJConsumerAffairs.gov/nursing)

**Employment Certification for the Reactivation of an 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)*

Are you currently working as a home health aide (H.H.A.), or did you work as an H.H.A. while your certification was lapsed or expired?

- Yes
- No

Provide an explanation: \_\_\_\_\_

Did you work as a H.H.A. while your certification was inactive?

- Yes
- No

Provide an explanation: \_\_\_\_\_

Were you terminated or asked to resign?

- Yes
- No

Provide an explanation: \_\_\_\_\_

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*

