

**CERTIFIED NURSING AIDE PRIVATE CARE**

State Form 52532 (R2 / 9-06)

INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF LONG TERM CARE

**INDIANA DEPARTMENT OF HEALTH
LONG TERM CARE**

2 N Meridian Street RM 4B

Indianapolis, IN 46204

Telephone: 317-233-3742

Fax number: 317-233-7750

*Your Social Security number is requested in accordance with the provision of IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

On an annual basis, the employer must inform the Indiana State Department of Health (ISDH) Nurse Aide Registry (NAR) that an individual Certified Nurse Aide (CNA) has performed "nursing or nurse-related services" activities for at least an eight-hour shift during a 24-month consecutive time period.

Please complete this form for each CNA who has worked at least 8 hours in a 24-month period. Based upon receipt and completion of this form, each CNA will be renewed for a 2-year period.

I. AIDE CERTIFICATION

Full Name of CNA					
CNA Street Address					
City		State		ZIP Code	
CNA Telephone Number				Date Of Birth	
Social Security Number*			CNA Registration Number		
Date of Hire			Date of Termination		
What type of nursing related duties did CNA perform? Please describe.					

II. CNA JOB FUNCTION

Please identify the number of hours within the last 24 consecutive months that this individual has performed "nursing or nursing-related services."

Number of Hours		Was CNA Paid?		Not Paid?	
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III. PERSON RECEIVING PRIVATE CARE

Name					
Address					
City		State		ZIP Code	

I HEREBY ATTEST THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Signature

Date

FOR OFFICE USE ONLY					
Expiration Date		Not on NAR			
Renewal Date		Initials		Date	