State of Illinois
Illinois Department of Public Health

U.S. Military Personnel Application to Become an Illinois Certified Nurse Aide (CNA)

Illinois Department of Public Health
Health Care Worker Registry, 525 W. Jefferson St., Fourth Floor, Springfield, IL 62761
Phone 217-785-5133 Fax 217-524-0137 E-mail DPH.HCWR@Illinois.gov

All information requested on this application must be provided before you will be evaluated. (Please type or print legibly)

Today's Date _____

Name _____ (First, Full Middle and Last)

Address _____ (Street, Apartment #, P. O. Box)

_____ (City, State, ZIP Code)

Telephone_____ Social Security Number_____ (required)

State(s) where you have been certified as a CNA_____

Name used when certified_____
If your current name is different from the name you used when you were certified, please attach a copy of the legal document(s) used to change your name (i.e. marriage certificate, divorce decree, etc.) and a copy of your driver's license or other picture identification.

Maiden name or other names you have been known by_____

Other states where you have lived or worked_____

I understand that the information requested regarding sex, race, height, eye color and date of birth is for the sole purpose of identification and gathering the background check information. This information will not be used to discriminate against me in violation of the law.

☐Male ☐Female Race _____ Height _____ Eye Color _____ Date of Birth _____
(Enter a letter from below)

- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undetermined race or of untold mixture
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of abuse, neglect or theft? ☐ Yes ☐ No
If "yes," indicate in what state this finding was issued_____

PHOTOCOPIES OF THE FOLLOWING DOCUMENTS MUST BE ATTACHED TO THIS FORM:

- Are you a U.S. citizen? ☐ Yes ☐ No **(If no, attach proof of employment authorization, such as a copy of your Resident Alien Card, U.S. Visa, or form I-94)**
- Proof of completing a hospital corpsman or medical service specialist training (Certificate or DD 214)

I hereby authorize the Illinois Department of Public Health, the Department's designee that trains or tests health care workers, a staffing agency, or the health care employer to request a fingerprint-based criminal history records check submitted as a fee applicant inquiry requested by the Department. I further authorize the Illinois State Police (ISP) to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency that maintains records relating to me, including but not limited to the Federal Bureau of Investigation or a local unit of government, to provide same on request to the ISP or the Department. I certify that the ISP and any agency, including the Department, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

Have you ever been convicted of a criminal offense, other than a minor traffic violation? ☐ Yes ☐ No

If "yes," provide the circumstance surrounding each offense (what happened, how many years have passed since the offense, the individuals involved, your age at the time of the offense, and any other circumstances surrounding the offense) as well as the state in which you were convicted. If you have been convicted in another state, you must provide information concerning those convictions or attach the complete results of a criminal history records check from that state. If you have a federal conviction, you must provide information concerning that conviction or attach the complete results of a criminal history records check from the Federal Bureau of Investigation. If more space is needed, please attach additional pages. Do not include convictions that have been expunged, sealed or was a juvenile adjudication.

I certify that the above is true and correct and give my consent for my name to appear on the Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____

Signature Date

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____

Signature Date

Mail this completed form to Illinois Department of Public Health, Health Care Worker Registry, 525 W. Jefferson St., Fourth Floor, Springfield, IL 62761. The Department will send you a Livescan Request Form by return mail. You will use the Livescan Request Form to have your fingerprints collected from one of the contracted livescan vendors.

A facsimile or photographic copy of this authorization will be as valid as the original.

If you meet Illinois' CNA requirements, an application for the written competency test will be mailed to you at the above address and you will be placed on the Health Care Worker Registry, which is the state's registry for CNAs. You may view the registry at http://www.idph.state.il.us/nar/home.htm. Otherwise, you will be sent written notification stating that you do not meet the requirements. Illinois does not issue any credentials or certificates to CNAs. **Incomplete applications will be returned to the address provided.**