

Louisiana Certified Nurse Aide Examination Application

Instructions

- Please go to <https://www.fletcher.edu/programs/nursing-allied-health/nurseaide> to print the current version of this application and all other forms. **DO NOT submit photocopies** as this may impact the ability to process the application.
- Incomplete, blurred or illegible forms **will not** be processed.
- All submitted applications **must** include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Fletcher Technical Community College, ATTN: LA Nurse Aide Program, 1407 Hwy 311, Schriever, LA 70395.**



The name you provide on this application **must** match **EXACTLY** the name on your government-issued identification you will provide on the day of testing. If the name does not match **EXACTLY**, you **will not** be permitted to take your exam and **will forfeit** any test fees.

If you have previously taken a nurse aide exam with Fletcher Technical Community College and your legal name has changed since then, you **must** provide a **copy** of acceptable legal documentation along with this application. Acceptable documents include marriage certificate; divorce decree; birth certificate; and legal name change court documents. Fletcher Technical Community College will be unable to process your application until the legal acceptable documents are received.

- **If applying for Testing Accommodations under the Americans with Disabilities Act (ADA):**
 - Please go to <https://www.fletcher.edu/programs/nursing-allied-health/nurseaide> to print the required ADA Accommodations Request Packet. This packet **MUST** be completed and submitted with this application.
 - Fill out the box below.

Note: Candidates applying to take the Oral (audio) Exam do not need to apply for ADA accommodations

I am applying for **Americans with Disabilities Act (ADA) accommodations**. I am requesting testing accommodations and have included the **required ADA Accommodations Request Packet** along with this application. I understand I must request accommodations **30 days in advance of the test date** and not **all** accommodations can be approved.

Yes

No

Candidate Information

All fields marked with * are required. Print one number/letter in each box where required.

| | | |
|--|------------------------------|-----------------------------|
| *Have you taken a Certified Nurse Aide exam with Fletcher? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Are you a high school student? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Social Security Number | | |
| *First Name | | Middle Initial |
| *Last Name | | |

| | | |
|---|---|---|
| *Date of Birth (Month/Day/Year) | Previous name (if applicable): | |
| *Street Address (including Apt. number or P.O. Box, if applicable) | | |
| *City | *State | *ZIP Code |
| Parish (first four letters only) | * Phone Number (including area code) | |
| *Email Address (application will not be processed without an email address) | | |
| Ethnic Group (optional) (check one box) | | |
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Asian American/Pacific Islander | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Mexican American | <input type="checkbox"/> Other Hispanic or Latin American | <input type="checkbox"/> White |
| <input type="checkbox"/> Other | | |
| Gender (optional) (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male | | |

Certification Option/Eligibility

Please check a certification route.

| | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | Certification Route |
| <input type="checkbox"/> | Route 1 New Nurse Aide: Candidate has completed training from a Louisiana approved training program within the last 12 months. |
| <input type="checkbox"/> | Route 2 Lapsed less than 24 Months: Candidate's Louisiana CNA certificate is lapsed less than 24 months and has one attempt to test and pass both parts of the exam. Louisiana Certificate # <input type="text"/> Expiration Date |
| <input type="checkbox"/> | Route 3 Lapsed and Re-trained: Candidate has lapsed on the Louisiana Registry and has completed a Louisiana approved training program within the last 12 months. Louisiana Certificate # _____ |
| <input type="checkbox"/> | Route 4 Foreign Trained Nurse (RN/LPN): Candidate is an RN or LPN who trained in a foreign country. Approval letter from LDH must be submitted with application. |
| <input type="checkbox"/> | Route 5 RN/LPN Student: Candidate has completed sufficient RN/LPN course content within the last 3 years. Transcript must be submitted to LDH for approval; approval letter must be included with application. |
| <input type="checkbox"/> | Route 6 Military Trained: Candidate has submitted military transcript which verifies sufficient medical training or experience to LDH for approval; approval letter must be included with application. |
| <input type="checkbox"/> | Route 7 Licensed Nurse on Suspended or Probation Status: Candidate has submitted documentation to LDH for approval; approval letter must be included with application. |

Training Information

This section must be completed if the **Certification Route 1 or 3** is selected.

| | | | |
|--|--|----------------------------------|----------|
| *Current/Anticipated Training Completion | | Training Program Code | |
| Date: | | NA | |
| *Name of Training Program | | | |
| *Training Program Mailing Address (Street Address or P.O. Box) | | | |
| City | | State | ZIP Code |
| Phone Number (including area code) | | Fax Number (including area code) | |
| Name of RN Coordinator | | Date | |

Test Site Information

Please check one of the following options.

| | | |
|-------------------------------------|--|------------------|
| <input checked="" type="checkbox"/> | Test Site | |
| <input type="checkbox"/> | Testing at your Facility: My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator. Do not send to Fletcher Technical Community College | |
| <input type="checkbox"/> | Regional Test Site: I am applying to test at a Regional Test Site. My preferred test site code is listed. <i>A current list of Test Sites with codes can be found online at https://cna-test-apply.dev.lctcs.edu/find-site.</i> | *Test site code: |

| | | | |
|-------------------------------------|---|------------|-------------------------------------|
| <input checked="" type="checkbox"/> | Testing Date Requested | | <input checked="" type="checkbox"/> |
| <input checked="" type="checkbox"/> | Newly Trained Tester | Fee | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | Written and Clinical Skills | \$100 | |
| <input type="checkbox"/> | Oral and Clinical Skills (includes Reading Comprehension Exam) | \$100 | |
| <input checked="" type="checkbox"/> | Lapsed/Other Candidate | Fee | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | Written and Clinical Skills | \$100 | |
| <input type="checkbox"/> | Oral and Clinical Skills (includes Reading Comprehension Exam) | \$100 | |
| <input checked="" type="checkbox"/> | Re-tester | Fee | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | Written Test ONLY | \$40 | |
| <input type="checkbox"/> | Oral Test ONLY (Oral includes Reading Comprehension Exam) | \$40 | |
| <input type="checkbox"/> | Clinical Skills Test ONLY | \$60 | |
| <input checked="" type="checkbox"/> | Rescheduling Fee | Fee | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | Test Rescheduling Fee | \$25 | |

Applicant's Affidavit and Candidate Release Statement

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand if any information given is not true, my registration status as a nurse aide may be at risk.
- I understand if I pass both parts of the Nurse Aide Competency Exam, I will be placed on the Louisiana Nurse Aide Registry.
- I understand I may be asked to play the part of the resident for another candidate on exam day.
- I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Fletcher Technical Community College, Louisiana Department of Health, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand all information required on the registration application may be made available for public disclosure (except for Social Security Number).

***Candidate Signature (in box below)**

Date:

If you are applying following Routes 4-7. If you **DO NOT** receive your emailed ATT letter from Fletcher Technical Community College within **10-14 business days** of receipt at Fletcher Technical Community College, please contact Fletcher Technical Community College.

Questions: For additional information, please visit our website at <https://www.fletcher.edu/programs/nursing-allied-health/nurseaide>.

Please make a copy of all completed forms for your personal records.