



CERTIFIED NURSING AIDE PRIVATE CARE

State Form 52532 (R/11-06)

Indiana State Department of Health-Division of Long Term Care

On an annual basis, the employer must inform the Indiana State Department of Health (ISDH), Nurse Aide Registry (NAR) that an individual Certified Nursing 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 that has worked for 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. CERTIFIED NURSING AIDE CERTIFICATION

Full Name of Certified Nursing Aide		
Certified Nursing Aide Street Address (<i>number and street</i>)		
City	State	ZIP
Certified Nursing Aide Telephone ()		
Social Security Number		Certified Nursing Aide Registration Number
Date of Hire (<i>month, day, year</i>)		Date of Termination (<i>month, day, year</i>)
Type of Nursing Related Duties Performed		

II. CERTIFIED NURSING AIDE JOB FUNCTION/PAY

Please identify the number of hours within the last 24-consecutive months that this individual has performed "nursing related services". Also please indicate if the CNA was paid while performing "nursing related services".

Number of Hours	Certified Nursing Aide Paid/Unpaid	
Facility Name		
Facility Address (<i>number and street</i>)		Telephone Number ()
City	State	ZIP

I hereby attest that the above information is true and accurate.

Signature

Date (*month, day, year*)

For Office Use Only	
Expiration Date (<i>month, day, year</i>)	Renewal Date (<i>month, day, year</i>)
Not on Registry	Already Updated
Initials	Date (<i>month, day, year</i>)