Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

Application for 2015 – 2017 Certificate Reactivation and Reinstatement of Ohio Certified Community Health Worker (CHW) Certificate

CHW.

DETAILED INSTRUCTIONS: Return the completed and signed application along with fee in the enclosed envelope.

- Complete the entire application, sign, and send appropriate fee.
- Incomplete applications will be returned and may be subject to fees.

FEE SCHEDULE & ACCEPTABLE FORMS OF PAYMENT: Payment must accompany this application.

- Fees must be **made payable to "Treasurer, State of Ohio"**.
- **Send a certified check, cashier's check, or money order**.
- Personal checks or cash will **NOT** be accepted.
- Business checks from government entities, corporations, and education or training programs will be accepted.
- Payments must be drawn on a United States (U.S.) bank or payable in U.S. dollars. **Fees are non-refundable**.

February 1 - March 1 (odd year)	**March 2 - March 31 (odd year)**	**All other dates**
Reactivation Fee: $35	Reactivation Fee: $85	Reactivation Fee: $35
Reinstatement Fee: $135	Reinstatement Fee: $185	Reinstatement Fee: $100

CONTINUING EDUCATION (CE): You are required to submit documentation of **15 contact hours** of continuing education completed during the twenty-four (24) months immediately preceding this application to reactivate/reinstate your certificate as follows:

- One **(1)** contact hour must be Category A (directly related to Ohio law & rules). Category A must be approved by the Board, an OBN approver, or offered by an OBN approved provider unit headquartered in the state of Ohio.
- One **(1)** contact hour must be directly related to establishing and maintaining professional boundaries.
- The remaining thirteen **(13)** contact hours must be an approved or accredited planned learning activity that builds upon a precertification education program and enables a certificate holder to acquire or improve knowledge or skills that promote professional or technical development to enhance the certificate holder's contribution to quality health care and pursuit of professional career goals.

COMPLIANCE: Check the appropriate box for **EACH** question and **send required documentation if applicable**.

CHANGE IN SOCIAL SECURITY NUMBER: Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (Public Law 100-93, Sec. 1921 of the Social Security Act, as amended; 45 C.F.R. pt. 60); reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, and/or as otherwise required by state and federal law.

If you have changed or obtained a new Social Security Number, please provide both your old AND new numbers

Old_____ New_____

CORRECTIONS & NAME/ADDRESS CHANGE: ***Skip this section if you have no changes. Make changes as applicable.***
You must submit a certified record of a name change (i.e. marriage certificate/abstract, divorce decree/dissolution, court record indicating the name change) within thirty days of the change. Certified court documents can be obtained from the court where the original record was filed. Photocopies or notarized copies are not acceptable for a name change.

Last Name_____

First, Middle Name_____

Address_____

City_____State_____Zip_____

County_____Telephone_____

Email_____

VERIFICATION: You must sign this CHW Reactivation/Reinstatement application.

COMPLETE APPLICATION ON BACK OF THIS FORM ➜ ➜ ➜ ➜ 2015

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CONTINUING EDUCATION (CE) *Check the CE box below.*

❑ I have met the CE requirements to reactivate/reinstate this CHW.

COMPLIANCE *Answer Yes or No to EACH question.*

☛ The following questions apply **SINCE** the submission of your last renewal application OR if this is your first renewal from the date your original certification application was filed. Have you been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program for any of the following crimes? This includes crimes that have been expunged if the crime has a direct and substantial relationship to practice as a community health worker.

	Yes	No	ANSWER EACH QUESTION
1a.	❑	❑	A felony in Ohio, another state, commonwealth, territory, province, or country? *If you answer "Yes", enter the court and case number.* Court Name:_____ Case#:_____
1b.	❑	❑	A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? This does not include traffic violations unless they are DUI/OVI or Physical Control While Under the Influence. *If you answer "Yes", enter the court and case number.* Court Name:_____ Case#:_____
2.	❑	❑	Has any board, bureau, department, agency or other body, including those in Ohio, **other than this Board**, in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation, or imposed a fine, censure, or reprimand against you? Have you voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?
3.	❑	❑	Have you for any reason, been denied an application, issuance, or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?
4.	❑	❑	Have you entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio, **other than this Board**?
5.	❑	❑	Have you been notified of any current investigation of you, or have you been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, **other than this Board**, with respect to a professional license, certificate, or registration?
6.	❑	❑	Have you been found to be a mentally ill person subject to hospitalization by court order, been found to be mentally incompetent by a probate court, or been found incompetent to stand trial by a court?
7.	❑	❑	Are you required to register, under Ohio law, the law of another state, the U.S., or a foreign country, as a sex offender?
8.	❑	❑	Have you been addicted to, dependent on, diagnosed with addiction, dependence or substance abuse disorder related to, or treated for addiction, abuse, dependence or substance disorder related to your use of alcohol or any chemical substance; or have you used any drugs that are illegal or were prescription drugs used by you without a legal, valid prescription?

☛ If you answer "Yes" to questions 1, 6, or 7, you are required to provide the Board with a written explanation of the events including the date, county, and state in which the events occurred, a certified copy of the indictment or criminal complaint, plea, or journal entry from the appropriate court(s). A copy of the court docket or case summary does not meet this requirement.

☛ If you answer "Yes" to questions 2, 3, 4, 5, or 8, you are required to provide the Board with a written explanation and certified copies of any documents (if applicable).

VERIFICATION *Sign below on the signature line.*

I am a U.S. citizen or lawfully admitted into the U.S. or I am a foreign national not living in the United States. I verify that all information on this form is true and accurate. I am aware that misrepresentation on this application may result in disciplinary action in accordance with Section 4723.86 ORC, and rules adopted thereunder.

SIGNATURE _____ 2015

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Supplemental Information For Reinstatement/Reactivation of Community Health Worker, Dialysis Technician, or Medication Aide

Applying to reinstate/reactivate (check all that apply):

☐ Community Health Worker (**CHW**)
☐ Medication Aide (**MA-C**)
☐ Ohio Certified Dialysis Technician (**OCDT**)

Ohio Certificate #_____ Date of Birth_____

Name_____
Last First Middle

Telephone #_____ Email_____

Have you worked in Ohio as a certificate holder since your Ohio certificate was inactive or lapsed?

☐ **No** (Skip lines 1-7 and sign and date this form)
☐ **Yes** (Complete lines 1-7 below and sign and date this form. If applicable, use additional pages to list employers for whom you worked between the time of your last active Ohio certificate and present date)

1) Employer/Facility_____ Supervisor_____
2) Address_____ City/State/Zip_____
3) Telephone_____ Dates of employment_____
4) Description of duties including your title_____
5) Did this position require an active Ohio certificate for CHW, MA-C, or OCDT ☐ Yes ☐ No
6) Did you practice in Ohio as a CHW, MA-C, or OCDT? ☐ Yes ☐ No
7) Did you use the title/initials of CHW, MA-C, or OCDT during this employment? ☐ Yes ☐ No

I certify that the information provided herein is true

Signature_____ Date_____

This form must be mailed to the Board, as an original signature is required. See address above.

2015