**STATE OF NEW HAMPSHIRE**

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

**DIVISION OF HEALTH PROFESSIONS**

**BOARD OF NURSING**

7 Eagle Square Concord, N.H. 03301

Telephone 603-271-6282 Fax 603-271-285656

# PRE-APPROVAL APPLICATION FOR NURSING ASSISTANT COMPETENCY TESTING

***Please attach appropriate educational documentation. Prior to submitting this application, please review the curriculum requirements of Nur 704.09 to ensure your education is "comparable" as required.***

| Last Name: | First Name: | Middle Initial: | Other Names Used: |
|---|---|---|---|
| Home Mailing Address: | | | |
| City: | State: | Zip Code: | |
| Date of Birth: | Social Security # (required) | Phone Number: | |

Do you now hold (or have you ever held) a nursing or nursing assistant certification, license or registration in New Hampshire or any other State? *YES ☐ NO ☐

*If Yes, please list the following information:

State ____________________ License Type ____________ Expiration Date ______________

Have you successfully completed a Nursing Assistant Program or education comparable within the past 5 years?

* YES ☐ NO ☐ *If Yes, attach official transcript or program letter.

Full Signature of Applicant: Date:

**This Section Is For Board of Nursing Use Only**

| | |
|---|---|
| Approved for Written & Clinical Competency Test: ☐<br>Written & Clinical Competency Test Denied: ☐ | Additional Information Needed: ☐<br>______________________<br>______________________<br>______________________ |

**THIS APPROVAL IS VALID FOR 120 DAYS**

Board of Nursing Signature: Date: