

HOME HEALTH AIDE (HHA) CERTIFICATION LIST

HHA Training Programs must use this form to submit student data to the Aide and Technician Certification Section (ATCS) for certification UPON COMPLETION of the HHA Training Program. DO NOT SEND ANY OTHER FORMS WITH THIS FORM.

Name of school or agency presenting program		<input type="checkbox"/> 40-hour program <input type="checkbox"/> 120-hour program	Date program began	Date program completed
Mailing address (number and street name or P.O. Box)	City	State	ZIP code	HHA School code

I certify that the students listed below have successfully completed an approved HHA Training Program, and qualify for HHA certification.

Signature of Registered Nurse (RN) responsible for HHA training program	Telephone Number ()
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1. Last Name	First Name	MI	Date of birth
Mailing address (number and street name or P.O. Box)		City	State ZIP Code
*Social Security Number _____ - _____ - _____		Telephone Number ()	

2. Last Name	First Name	MI	Date of birth
Mailing address (number and street name or P.O. Box)		City	State ZIP Code
*Social Security Number _____ - _____ - _____		Telephone Number ()	

3. Last Name	First Name	MI	Date of birth
Mailing address (number and street name or P.O. Box)		City	State ZIP Code
*Social Security Number _____ - _____ - _____		Telephone Number ()	

4. Last Name	First Name	MI	Date of birth
Mailing address (number and street name or P.O. Box)		City	State ZIP Code
*Social Security Number _____ - _____ - _____		Telephone Number ()	

5. Last Name	First Name	MI	Date of birth
Mailing address (number and street name or P.O. Box)		City	State ZIP Code
*Social Security Number _____ - _____ - _____		Telephone Number ()	

6. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
7. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
8. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
9. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
10. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
11. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		
12. Last Name		First Name	MI	Date of birth	
Mailing address (number and street name or P.O. Box)			City	State	ZIP Code
*Social Security Number _____ - _____ - _____			Telephone Number ()		

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

INFORMATION COLLECTION AND ACCESS-PRIVACY STATEMENT

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code, Section 17520, subdivision (d), the California Department of Public Health (CDPH), is required to collect social security numbers from all applicants for nursing assistant certificates, home health aide certificates, hemodialysis technician certificates or nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Health Integrity and Protection Data Bank as required by 45, CFR §61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for examination identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.