State of Ohio
Department of Health
Office of Health Assurance and Licensing

Nurse Aide Registration Form (HEA 7713)

This form gives the Ohio Nurse Aide Registry the required information necessary to update nurse aides' employment so they will remain active and in good standing on the Ohio Nurse Aide Registry.

In order for the nurse aides included in this document to be re-registered, they must have provided for compensation, nursing or nursing-related services for at least 7.5 consecutive hours or 8 hours in a 48-hour period, all within the last 24 months.

Instructions for Use:

List all nurse aides used by the facility since the last survey that meet the above criteria, including aides through temporary staffing services.

The **definition** of "**Last Date Used**" is the last date the nurse aide worked as an aide in your facility. In the "Last Date Used" box, **do not use** the word "**current**" or leave**" blank"** when completing the form. The word "**current**" or a **blank** space does not accurately reflect the last date the nurse aide was used as a nurse aide or the last date the nurse aide was employed by your facility. Failure to complete this form accurately will cause the nurse aides' information to reflect inaccurate data and may possibly cause the nurse aides' registration to expire. Incomplete forms will be returned for correction.

Forms are available online at the Ohio Department of Health website: www.odh.ohio.gov

Contact the Nurse Aide Registry by phone at (800) 582-5908 (in state only); or (614) 752-9500; by fax at (614) 564-2461; or by e-mail at NAR@odh.ohio.gov. The Nurse Aide Registry is accessible online at http://www.odh.ohio.gov/odhPrograms/io/nurseaide/nurseaide1.aspx

NOTE: If your facility is not Medicare certified, the Registry will return the completed HEA 7713 and request that the following statement is returned with completed HEA 7713 form. Ohio Administrative Code OAC 3701-17-07.1 (C)(1)

1. *A statement by a physician or nurse verifying that he or she has personal knowledge that the individual provided nursing and nursing-related services to a patient under the physician's or nurse's care. The statement shall further verify:*

    - *The name of the individual that provided nursing and nursing-related services for such patient;*

    - *The nature of the nursing and nursing-related services and the date or dates the individual last provided seven and one-half consecutive hours or eight hours in a forty-eight hour period of nursing and nursing related services;*

    - *That the individual received compensation for the services specified in paragraph (D)(2)(b) of this rule. If the physician or nurse is unable to verify that the individual was compensated for those services, the individual must provide further proof that he or she received compensation for the specified services.*

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Nurse Aide Registration Form (Facility)

Section I (Facility Information)

Facility Name:		Facility Medicare Number: (i.e. 36 _ _ _ _)	
Street Address:			
City:	County:	State:	ZIP:
Telephone:	FAX:	Name of Person to Contact: Email (s):	

Type of Facility:

☐Nursing Home ☐Hospital ☐RCF
☐Home Health Agency ☐Hospice ☐ACF
☐ICF/MR ☐Staffing Agency ☐Other (please describe)_________________________

Name of Home Administrator:	License Number:	Name of Director of Nursing:	License Number:
Signature of Home Administrator:		Signature of Director of Nursing:	

Section II (Nurse Aide Information)
*List **all** nurse aides used by the facility, including aides used through temporary staffing services:*

Name (Last, First, MI):			NAR Number	
Street Address:		Date of Hire:	Last Date Used:	
City:	County:		State:	ZIP:

Name (Last, First, MI):			NAR Number	
Street Address:		Date of Hire:	Last Date Used:	
City:	County:		State:	ZIP:

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Nurse Aide Registration Form (Facility) (Continued)

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Street Address:		Date of Hire:	Last Date Used:	
City:	County:		State:	ZIP:

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City:	County:		State:	ZIP:

Name (Last, First, MI):			NAR Number	
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City:	County:	State:	ZIP:

Nurse Aide Registration Form (Facility) (Continued)

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