State of Illinois
Illinois Department of Public Health

Reinstatement of Inactive Certification as Illinois Certified Nurse Aide (CNA)
As Provided by Executive Order 2020-12
Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761
Phone: 844-789-3676 Fax: 217-524-0137 Email: DPH.HCWR@illinois.gov

All information requested on this application must be provided before your certification will be reinstated.
(Please type or print legibly)

Today's Date: _____

Name: _____ (First, Full Middle and Last)

Address: _____ (Street, Apartment #, P. O. Box)

_____ (City, State, ZIP Code)

Email: _____

Telephone: _____ Social Security Number: _____

Maiden name or other names by which you have been known: _____

Date when you were certified as a CNA: _____

Date you last worked as a CNA: _____

Name of facility where you last worked as a CNA: _____

NOTE: You are eligible to have your inactive CNA certification reinstated under the terms of Executive Order 2020-12 **only** if your certification has been **inactive for less than five years**. If your certification has been inactive longer than five years, you must complete a manual skills assessment and pass the written CNA exam before your certification can be active again.

I understand that the information requested regarding sex, race, height, weight, eye color, and date of birth is for the sole purpose of identification and gathering the background check information. This information will not be used to discriminate against me in violation of the law.

☐ Male ☐ Female Race_____ Height_____ Weight _____ Date of Birth _____
(Enter a letter from below)
Hair Color _____ Eye Color _____ Place of Birth _____

- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition
- **U** Of undetermined race or of untold mixture
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of abuse, neglect or theft? ☐ Yes ☐ No

If "yes," indicate in what state this finding was issued_____

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I hereby authorize the Illinois Department of Public Health, the Department's designee that trains or tests health care workers, a staffing agency, or the health care employer to request a fingerprint-based criminal history records check submitted as a fee applicant inquiry requested by the Department. I further authorize the Illinois State Police (ISP) to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency that maintains records relating to me, including but not limited to the Federal Bureau of Investigation or a local unit of government, to provide same on request to the ISP or the Department. I certify that the ISP and any agency, including the Department, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I certify that the above is true and correct and give my consent for my name to appear on the Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
Signature Date

Mail this completed form to Illinois Department of Public Health, Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761. Alternatively, you may **fax** this form to (217) 524-0137 or **scan (as a PDF document) and e-mail** this form to DPH.HCWR@illinois.gov.

If you meet the requirements spelled out in Executive Order 2020-12, your CNA certification will be reinstated as active. If you do not meet the requirements, you will be sent written notification stating that you do not meet those requirements. Illinois does not issue any credentials or certificates to CNAs. **Incomplete applications will be returned to the address provided.**

DO NOT WRITE BELOW THIS LINE
(For Department Use Only)

Work Eligibility: ELIGIBLE _____ INELIGIBLE/REASON (ANT or DQ) _____ NOT YET DET. _____

Date of last competency examination: _____ Employment gaps?* (Dates): _____

End date of last work history: _____ Date deemed inactive**: _____

Approved for reinstatement: YES _____ NO _____ DATE/INITIALS _____

*NOTE: Employment gaps of more than 24 months **prior** to start of last Work History indicate that the CNA was already inactive; therefore, that CNA would not be eligible for reinstatement unless inactive for less than five years **including** the gap(s).

**Date deemed inactive is the date 24 months after the end date of the most recent Work History.