**HOME HEALTH AIDE ATTESTATION OF TRAINING AND COMPETENCE**

**(ENDORSEMENT)**

**EMERGENCY RULE-MAKING 9-21-2022**

**PART 1: To be completed by the applicant**

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| --- | --- |
| NAME (Last, First, Middle) | Date of Birth (MM/DD/YYYY) |
| Social Security Number  | Applicant’s Maryland License Info:Training Program/School’s Name  |
| Name and Address of Employer | Employer’s No. and Email address |

 **PART 2: To be completed by employer.** I hereby state, to the best of my information, knowledge, and belief, the information provided in this document is true and correct. The applicant completed a training program as a nursing assistant. He or she is competent to provide patient care as a Home Health Aide.

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| --- | --- |
| Hire Date:  |  |
| Employer‘s Authorizing Rep. (Print name) | Employer’s Authorizing Rep. Title  |
| Employer’s State License No.  | Employer’s Authorizing Rep. Signature and Date |

**PART 3: To be completed by the supervising nurse.** I, this applicant’s supervising nurse confirm that the person is competent and attest that an evaluation was completed within fourteen (14) days of hire and included an assessment of the Maryland CNA’s ability to provide the following services in accordance with 17 DCMR § 9306.2 (Emergency Rulemaking 9-21-22):

 (A) Assistance during emergencies in the home, including power outages, weather conditions, basic disaster procedures, emergency evacuation procedures (including assistive devices for evacuation), fire safety in the home, and steps to take in case of fire to ensure client safety;

(B) Basic food and nutrition, including safe food storage, safe meal preparation, meal planning, and modified diets;

(C) Proper use of assistive devices and lifts for in-home use; and

(D) Skilled services, including changing non-sterile dressings and simple dressings.

 I hereby attest that the information provided is true to the best of my knowledge. Making a false statement may result in DC HEALTH taking action that it deems appropriate.

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| Skills Evaluation Date: | Skills Evaluation Completed by: (Print Name) |
| Supervising Nurse (Print name)  | Supervising Nurse License state and No. |
| Supervising Nurse Signature  | Date:  |