Oklahoma State Department of Health
Nurse Aide & Nontechnical Services Worker Registry
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Oklahoma City, OK 73126-8816
(405) 426-8150
Fax: (405) 900-7572
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NURSE AIDE TEMPORARY EMERGENCY WAIVER APPLICATION

Nurse Aide Temporary Waiver Application

Pursuant to the certified nurse aide requirements in 63 O.S. Section 1-1950.3(A)(2) a nursing facility, specialized facility, continuum of care facility, assisted living center, adult day care center, or residential care home may apply for a nurse aide temporary emergency waiver. Complete this application and submit it to the Nurse Aide Registry along with the applicable fee to the address above.

Check one. ☐ Initial Application Fee $100 ☐ Renewal Application Fee $75 (see addition requirement below)

Facility License ID _____

Name of Facility, Center, or Home _____

Street Address _____ **City** _____ **Zip Code** _____

A. Has the facility, center, or home made diligent efforts to recruit and retain certified nurse aides? ☐ Yes ☐ No

If yes, *attach documentation* proving one or more of the following:

☐ Advertised for CNAs in the area (DATES) ☐ Offered competitive salary

☐ Retention incentives ☐ Recruitment incentives

If the reply to A is "No" the applicant is not eligible to receive a waiver. Date of last Survey:

B. Has an OSDH inspection or investigation been conducted at this facility, center, or home since July 11, 2005? ☐ Yes ☐ No

If the reply to B is "no" the applicant is eligible to receive a waiver. Skip to Item E.

If the reply to B is "yes" answer Items C and D based on inspections and investigations.

C. Did the Department (OSDH) cite any deficiencies or violations relating to the following?

1. Failure to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents, clients, or participants and misappropriation of resident, client, or participant property. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

2. Failure to implement infection control procedures. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

3. Failure to ensure staff members observe resident, client, or participant rights and responsibilities. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

4. Failure to comply with criminal history background checks in accordance with O.S. 63:1-1950.1. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

5. Failure of a nurse aide to perform proficiently on nursing or personal care services. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

6. A finding of a lack of nurse aide competency. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

7. Failure to conduct performance appraisals or training for nurse aides. ☐ Yes ☐ No

If yes, date this deficiency/violation was corrected. _____

If the replies to all of the Items C1 through C7 are "No" the applicant is eligible to receive a waiver. Skip to Item E.

If the reply to any of the Items C1 through C7 is "Yes" and the deficiency has not been corrected, the applicant is not eligible to receive a waiver. Reply to Item D.

If the reply to any of the Items C1 through C7 is "Yes" and the deficiency has been corrected, reply to Item D.

D. Was any deficiency cited in relation to Items C1 through C7 based on activity or inactivity of an uncertified nurse aide that caused a resident serious injury, harm, impairment, or death? ☐ Yes ☐ No

If the reply to Item D is "Yes" the applicant is not eligible to receive a temporary emergency waiver.

E. How many persons do you expect to be employed during the effectiveness of the waiver?

Certified Nurse Aides _____ Uncertified Nurse Aides _____ Other Direct Care Staff _____

F. **1.** Explain why the facility is unable to meet the staffing requirements.

2. Explain how the uncertified nurse aides will be trained and evaluated, and where they will be trained. Explain how will they be utilized by the facility during the waiver period.

G. If renewing, include a NATCEP Status Report (ODH 297.1) for each uncertified nurse aide employed during the preceding waiver period.

H. By my signature below, I attest this application is true to the best of my knowledge and belief.

_____
Typed or Printed Name of Person Completing this Form

Phone Number and Extension_____ E-Mail _____

_____ _____
Signature Date Signed

Note: Please mail this completed application and fee to the address at the top right on page one of this application.

Submission of an incomplete application, non-current license, or no fee will result in a delay or disapproval of the waiver.