



Board of Nursing

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

ATTESTATION FORM FOR TEMPORARY NURSE AIDES

This Attestation Form must be completed by the applicant, the registered nurse (“RN”) who instructed and/or supervised the applicant, and the administrator or director of nursing (“DON”) of the nursing facility or skilled nursing facility at which the applicant worked as a temporary nurse aide (“TNA”) in Maryland during the COVID-19 Public Health Emergency pursuant to the waivers issued by the Centers for Medicaid and Medicare Services.

In order to complete this Attestation Form, an RN Instructor/Supervisor must have witnessed and/or have personal knowledge that the on-the-job training of the applicant met the requirements under 42 CFR § 483.152(a) and (b)(2)-(7). If there was more than one RN instructor for or supervisor of the applicant, such that more than one RN must complete this form in order to attest that the applicant fully met the requirements under 42 CFR § 483.152(a) and (b)(2)-(7), please have the additional RN(s) also initial where applicable and complete the last page of this document. If necessary, the initials of more than one instructor may be placed in an answer to a question.

Please review the Guidance Document that accompanied this Form for additional information and instruction on completing this Attestation Form.

I. Applicant Information *(must be completed by Applicant)*

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Email Address: _____

II. RN Instructor/Supervisor Information *(must be completed by RN)*

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Email Address: _____

RN License Number: _____

III. Facility Information *(must be completed by Administrator or DON)*

4140 Patterson Avenue - Baltimore, Maryland 21215-2254
Toll Free: 1 (888) 202 – 9861 • Phone: (410) 585 – 1900 • TTY/TDD: 1 (800) 735 – 2258
Fax: (410) 358 - 3530
www.mbon.maryland.gov

TNA Attestation Form

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Administrator Name: _____ Phone Number: _____

Director of Nursing Name: _____ RN License Number: _____

Date of Employment of Applicant: _____ Still employed? _____

IV. Eligibility

Please initial next to your answer to each question where prompted.

1. Did the above-named applicant complete an 8-hour online training and examination program offered by the American Health Care Association, the National Center for Assisted Living, or another comparable program approved by the Board?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

2. Did the above-named applicant complete a minimum of 100 hours of on-the-job training as a TNA?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

3. Did the on-the-job training of the above-named applicant include basic nursing skills, including all of the following:

- a. Taking and recording vital signs;
- b. Measuring and recording height and weight;
- c. Caring for the residents' environment;
- d. Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and
- e. Caring for residents when death is imminent?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

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4. Did the on-the-job training of the above-named applicant include personal care skills, including all of the following:

- a. Bathing;
- b. Grooming, including mouth care;
- c. Dressing;
- d. Toileting;
- e. Assisting with eating and hydration;
- f. Proper feeding techniques;
- g. Skin care; and
- h. Transfers, positioning, and turning?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

5. Did the on-the-job training of the above-named applicant include mental health and social service needs, including all of the following:

- a. Modifying aide's behavior in response to residents' behavior;
- b. Awareness of developmental tasks associated with the aging process;
- c. How to respond to resident behavior;
- d. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and
- e. Using the resident's family as a source of emotional support?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

6. Did the on-the-job training of the above-named applicant include care of cognitively impaired residents, including all of the following:

- a. Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);
- b. Communicating with cognitively impaired residents;
- c. Understanding the behavior of cognitively impaired residents;
- d. Appropriate responses to the behavior of cognitively impaired residents; and
- e. Methods of reducing the effects of cognitive impairments?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

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7. Did the on-the-job training of the above-named applicant include basic restorative services, including all of the following:

- a. Training the resident in self care according to the resident's abilities;
- b. Use of assistive devices in transferring, ambulation, eating, and dressing;
- c. Maintenance of range of motion;
- d. Proper turning and positioning in bed and chair;
- e. Bowel and bladder training; and
- f. Care and use of prosthetic and orthotic devices?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

8. Did the on-the-job training of the above-named applicant include Residents' Rights, including all of the following:

- a. Providing privacy and maintenance of confidentiality;
- b. Promoting the residents' right to make personal choices to accommodate their needs;
- c. Giving assistance in resolving grievances and disputes;
- d. Providing needed assistance in getting to and participating in resident and family groups and other activities;
- e. Maintaining care and security of residents' personal possessions;
- f. Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff; and
- g. Avoiding the need for restraints in accordance with current professional standards?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

9. If "No" was the answer to any question in Questions 3-8, was supplemental training in the subject matter(s) not included in the on-the-job training provided by the RN instructor?

Applicant: _____ Yes _____ No

Instructor: _____ Yes _____ No

If yes, please list the areas in which supplemental training was provided and the date of that supplemental training:

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10. Did the above-named applicant work as a TNA for a minimum of 160 hours (in addition to the minimum of 100 hours of on-the-job training)?

Administrator/DON: _____ Yes _____ No

11. Did the above-named applicant demonstrate competency in all subject matters listed in Questions 3-8 throughout the 160 hours of working as a temporary nurse aide?

Instructor: _____ Yes _____ No

12. If the answer to Question 11 is “No,” was supplemental training provided to the applicant?

Instructor: _____ Yes _____ No

If yes, please list the areas in which supplemental training was provided and the date provided:

13. Did the facility ensure that the above-named applicant did not perform any services for which the applicant had not been trained and found proficient by the instructor?

Instructor: _____ Yes _____ No

14. Did the facility ensure that the above-named applicant was under the general supervision of a licensed nurse or registered nurse?

Instructor: _____ Yes _____ No

Administrator/DON: _____ Yes _____ No

15. Did the RN instructor(s) meet the following requirements:

- a. Possess a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long-term care facility services; and
- b. Either complete a course in teaching adults or have experience in teaching adults or supervising nurse aides?

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Instructor: _____ Yes _____ No

Administrator/DON: _____ Yes _____ No

16. If the training was performed under the general supervision of the DON for the facility, was the DON prohibited from performing the actual training?

Instructor: _____ Yes _____ No _____ N/A

Administrator/DON: _____ Yes _____ No _____ N/A

17. If there were personnel from other health professions supplementing the RN instructor(s), did that individual have at least 1 year of experience in their fields?

Administrator/DON: _____ Yes _____ No _____ N/A

18. In the previous two years from the date training of the above-named applicant began, did any of the following apply to the facility:

- a. In the case of a skilled nursing facility, has operated under a waiver under section 1819(b)(4)(C)(ii)(II) of the Act;
- b. In the case of a nursing facility, has operated under a waiver under section 1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the facility is unable to provide nursing care required under section 1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours per week;
- c. Has been subject to an extended (or partial extended) survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;
- d. Has been assessed a civil money penalty described in section 1819(h)(2)(B)(ii) of 1919(h)(2)(A)(ii) of the Act of not less than \$5,000 as adjusted annually under 45 CFR part 102; or
- e. Has been subject to a remedy described in sections 1819(h)(2)(B)(i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A)(i), (iii) or (iv) of the Act?

Administrator/DON: _____ Yes _____ No

19. From the date that training of the above-named applicant began, have two years elapsed since the assessment of the following penalty (or penalties) to the facility:

- a. Had its participation terminated under title XVIII of the Act or under the State plan under title XIX of the Act;
- b. Was subject to a denial of payment under title XVIII or title XIX;
- c. Was assessed a civil money penalty of not less than \$5,000 as adjusted annually under 45 CFR part 102 for deficiencies in nursing facility standards;
- d. Operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of its residents; or

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e. Pursuant to State action, was closed or had its residents transferred?

Administrator/DON: _____ Yes _____ No

V. Applicant Attestation

By signing this form, I hereby declare and attest that my answers to the questions listed on this form are true and correct to the best of my knowledge.

I understand that providing any false or misleading information on this attestation form constitutes a fraudulent or deceptive attempt to obtain a certificate and may subject me to discipline under the Maryland Nurse Practice Act, including denial of certification.

Signature of Applicant

Date

NOTARIZATION

STATE: _____

CITY/COUNTY: _____

I HEREBY CERTIFY that on this _____ day of _____, 2022, before me, Notary Public of the State and City/County aforesaid, _____, personally appeared, and declared and affirmed under penalties of perjury that signing the foregoing Attestation Form was his/her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SEAL

Notary Public

My Commission Expires: _____

TNA Attestation Form

VI. RN Instructor/Supervisor Attestation

By signing this form, I hereby declare and attest that my answers to the questions listed on this form are true and correct to the best of my knowledge. I further declare and attest that I witnessed and/or have personal knowledge that the above-named applicant satisfactorily completed on-the-job training and supplemental training, if any, as documented above on this form. I further declare and attest that I have witnessed and/or have personal knowledge that the above-named applicant has practiced competently in the areas identified above on this form.

I understand that providing any false or misleading information on this attestation form constitutes a fraudulent or deceptive attempt to obtain a certificate for another and may subject me to discipline under the Maryland Nurse Practice Act, including reprimand, probation, suspension, revocation and/or a monetary penalty.

Signature of RN Instructor/Supervisor

Date

NOTARIZATION

STATE: _____

CITY/COUNTY: _____

I HEREBY CERTIFY that on this _____ day of _____, 2022, before me, Notary Public of the State and City/County aforesaid, _____, personally appeared, and declared and affirmed under penalties of perjury that signing the foregoing Attestation Form was his/her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SEAL

Notary Public

My Commission Expires: _____

TNA Attestation Form

VII. Administrator/DON Attestation

By signing this form, I hereby declare and attest that my answers to the questions listed on this form are true and correct to the best of my knowledge.

I understand that providing any false or misleading information on this attestation form constitutes a fraudulent or deceptive attempt to obtain a certificate for another and may subject me to discipline under the Maryland Nurse Practice Act, including denial, reprimand, probation, suspension, revocation, and/or monetary penalty.

Signature of Administrator/DON

Date

NOTARIZATION

STATE: _____

CITY/COUNTY: _____

I HEREBY CERTIFY that on this _____ day of _____, 2022, before me, Notary Public of the State and City/County aforesaid, _____, personally appeared, and declared and affirmed under penalties of perjury that signing the foregoing Attestation Form was his/her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SEAL

Notary Public

My Commission Expires: _____

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PAGE FOR ADDITIONAL RN INSTRUCTOR(S)/SUPERVISOR(S) ONLY

RN Instructor/Supervisor Information *(must be completed by RN)*

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Email Address: _____

RN License Number: _____

RN Instructor/Supervisor Attestation

By signing this form, I hereby declare and attest that my answers to the questions listed on this form are true and correct to the best of my knowledge. I further declare and attest that I witnessed and/or have personal knowledge that the above-named applicant satisfactorily completed on-the-job training and/or supplemental training as documented above on this form. I further declare and attest that I have witnessed and/or have personal knowledge that the above-named applicant has practiced competently in the areas identified above on this form. I understand that providing any false or misleading information on this attestation form constitutes a fraudulent or deceptive attempt to obtain a certificate for another and may subject me to discipline under the Maryland Nurse Practice Act, including reprimand, probation, suspension, revocation and/or a monetary penalty.

Signature of RN Instructor/Supervisor

Date

NOTARIZATION

STATE: _____

CITY/COUNTY: _____

I HEREBY CERTIFY that on this _____ day of _____, 2022, before me, Notary Public of the State and City/County aforesaid, _____, personally appeared, and declared and affirmed under penalties of perjury that signing the foregoing Attestation Form was his/her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

SEAL

Notary Public

My Commission Expires: _____