GOVERNMENT OF THE UNITED STATES VIRGIN ISLAND
-----●-----
BOARD OF NURSE LICENSURE
P.O. Box 304247
St. Thomas, Virgin Islands 00803
9150 Estate Thomas, Suite 206, St. Thomas, VI 00802
(340) 249-0684 ext: 5681 or (340) 690-9326

Dear Applicant,

Enclosed please find information about the procedure required for endorsement of your Certified Nursing Assistant Certification so that you may practice in the United States Virgin Islands.

Note: *Your application for endorsement and processing fee will remain active for one year from the date of submission.*
Please follow the steps below to prepare your packet:

1. Complete, sign, date, and notarize the attached application.

2. Submit proof of Social Security.

3. Two (2) recent passport "2x2" photos. *Please print your name and sign the back of each photo; attach one photo to your application; and the second to your official verification form.*

4. Please attach the following documents validating proof of Education:
   a) Legible copy of your High School Diploma or the equivalent thereof.
   b) Legible copy of your Nursing Assistant Certificate/Diploma or an official copy of your Nursing Transcript.
5. A copy of an unencumbered Nursing Assistant State Certificate that will not expire 90 days from the date on your application.

6. Please complete and submit the Official Verification form to your State Board of Nursing (BON) or Agency. *This form should be completed by your BON/Agency and forwarded directly to the Virgin Islands Board of Nurse Licensure (VIBNL*).

7. ***$ 75.00*** CNA Endorsement processing fee is payable by money order or certified bank check.
   Fees are non-refundable and not transferable. Personal Checks are not accepted.

   Make Certified Checks and Money Orders payable to the:
   Virgin Islands Board of Nurse License
   P.O. Box 304247
   St. Thomas, VI 00803

8. Documents - To support any changes in name (i.e. - marriage license, divorce decree with name change) must be included.

9. Name/Address Change - Notify the Board in writing of change of name, address, or telephone
   number. Please include official supporting documentation of name change (e.g. marriage license).

Please Note:
Self-Disclosure of all misdemeanors, felonies, plea agreements (even if adjudication was withheld), any substance use disorder in the last 5 years, and any actions taken or initiated against a professional or occupational license, registration, or certification is required.

Certified Nurse Assistants must obtain certification to practice nursing within the territory of the US Virgin Islands before reporting to their employment. Please notify the VIBNL if you intend to pick up your Certification ID Card. Picture Identification will be required to pick up Certification Card, once you have been notified by the board that it is ready for pick up. Office hours are Monday through Friday, from 8:30am to 4:00pm.

Further information may be obtained by calling the V.I. Board of Nurse Licensure Office at (340) 249-0684.

Thank you for your interest in nursing in the United States Virgin Islands.

Sincerely,
Chairperson, VIBNL

PLEASE ALLOW NINETY (90) BUSINESS DAYS AFTER VIBNL RECEIPT OF ALL REQUIRED DOCUMENTS FOR THE PROCESS OF YOUR REQUEST TO BE COMPLETED.

GOVERNMENT OF THE UNITED STATES VIRGIN ISLAND
-----●-----
BOARD OF NURSE LICENSURE
P.O. Box 304247
St. Thomas, Virgin Islands 00803
9150 Estate Thomas, Suite 206, St. Thomas, VI 00802
(340) 249-0684 or (340) 690-9326

APPLICATION FOR ENDORSEMENT AS A CERTIFIED NURSE ASSISTANT

1. Name in full _____
   a. (Print) Last First Middle Maiden
2. Mailing Address _____ Soc. Sec# _____
3. Email Address _____Tel. # _____
4. DOB_____ Birthplace _____Marital Status: S M D W
5. Are you a US citizen? Yes ( ) No ( ) Give visa status
   _____
6. How would you rate your own general physical and mental health?
   _____
7. Do you have a disability that should be reported to this Board? _____
8. Were you ever issued a license/certificate to practice nursing within the US Virgin Islands? Yes ( ) No ( )
9. If yes, please provide: VI License/Certification number: _____ Expiration date:_____
10. Are you currently registered/certified as a Nurse Assistant? Yes ( ) No ( )
    If yes, give the name and complete address of the agency which issued the state approved Certified Nursing Assistant certificate:
    _____

EDUCATION:

High School _____ Date of Graduation _____

Nurse Aide Program _____ Date of Graduation _____

Address of Nurse Aide Program_____

Length of Nurse Aide Program _____

Have you taken the National Nursing Assistant Certifying Examination? Yes ( )
No ( )

If yes, please provide the complete address of where the exam was taken and the date it was taken_____

List the names of three (3) immediate supervisors (within the last 3 years) and employment contact information

Supervisor's Name: _____ Facility _____ Address _____Phone: _____

Employment Dates: From_____ To: _____

Supervisor's Name: _____ Facility _____

Address _____ Phone: _____ Employment Dates: From_____ To: _____

Supervisor's Name: _____ Facility _____

Address _____Phone: _____ Employment Dates: From_____ To: _____

Please Note:

Self-disclosure of all misdemeanors, felonies, plea agreements (even if adjudication was withheld), any substance use disorder in the last five (5) years, and any actions taken or initiated against a professional or occupational license, registration, or certification is required. Failure to do so may result in a disciplinary action by the VIBNL.

Has there been any complaints or disciplinary action taken or pending against your professional nursing or occupational license, registration, or certification? Yes ( ) No ( )
If yes, please provide the jurisdiction(s), license(s), date(s) and a description of the action taken.

Have you been convicted of a felony, committed any misdemeanors, or entered into a plea agreement, (even if adjudication was withheld) during the past five 5 years? Yes ( ) No ( ) If yes, please forward supporting documents.

My signature on this application constitutes my express authorization for the Government of the US Virgin Islands, Department of Health, Board of Nurse Licensure and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal, or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained in the foregoing applications. I understand that this authorization is for the express purpose of determining that I am of good character pursuant to the Nurse Practice Act, codified in Title 27, Chapter 1, Section 91, et seq., of the Virgin Islands Code and Executive Order No. 378-1998.

_____YES _____NO

Notary Public Seal _____ _____

Signature (Applicant's Signature) Date

_____

Date

Office Use Only:

_____ _____

Initial **Date**