



Attestation of Community Health Worker Training Program Completion Form A

Part 1-General Information-Please Print

(Applicant must complete this part and send to the community health worker training program)

Full Legal

Name _____
Last First Middle Maiden

Social Security Number* _____

Telephone Number _____ Email Address _____

Signature _____ Date _____

Part 2-Attestation of Completion of Community Health Worker Training Program-Please Print

(Community health worker training program representative must complete this part and send directly to the Board)

Program Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number of Program _____

I hereby verify that the applicant named above has successfully completed the above named community health worker training program on _____ and is competent to provide care as a community health worker.
Month/Day/Year

Name of Training Program Representative (Print)

Title of Training Program Representative (Print)

Telephone Number of Training Program Representative

Signature of Training Program Representative

Date

*Your social security number is required by state law and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60), reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

Please submit this form to: Ohio Board of Nursing, Attention: CHW, 17 South High Street, Suite 400, Columbus, OH 43215-7410
OR Fax to (614) 466-0388.