MAIL OR FAX FORM TO:

California Department of Public Health (CDPH)
Licensing and Certification Program (L&C)
Aide and Technician Certification Section (ATCS)
MS 3301, P.O. Box 997416
Sacramento, CA 95899-7416

PHONE: (916) 327-2445 FAX: (916) 552-8785

## HOME HEALTH AIDE (HHA) CERTIFICATION LIST

HHA Training Programs must use this form to submit student data to the Aide and Technician Certification Section (ATCS) for certification UPON COMPLETION of the HHA Training Program.

DO NOT SEND ANY OTHER FORMS WITH THIS FORM.

All data fields are required fields. If all data is not provided the form will not be processed.

			40-hour program 120-hour program	Date progra	am began	Date program completed		
Mailing address (number and street name or P.O. Box)  City				State	ZIP code	HHA School code	-	
I certify that the students listed below have	e successfully c	ompleted an a	pproved HHA Train	ing Program,	and qualify for	HHA certification.		
Signature of Registered Nurse (RN) responsible for HHA training program  Date				Telephone Number				
1. Last Name	First Name			MI	Date of birth			
Public Address (Required) - Subject to Public Record	s Act request releas	se*	City		State	e ZIP Code		
Confidential Address (For CDPH use only. If left blank all d	ove) City		State	ZIP Code				
Social Security Number** (SSN) or Individual Taxpayer Identification Number (ITIN)			Phone Number***	Phone Number***  Check if this is a cell phone				
2. Last Name	First Name			MI	Date of birth			
Public Address (Required) - Subject to Public Records Act request release*			City	Sity		ZIP Code		
Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to address above)			ove) City		State	e ZIP Code		
Social Security Number** (SSN) or Individual Taxpayer Identification Number (ITIN)			Phone Number***	Phone Number***  Check if this is a cell phone				
3. Last Name	First Name			MI	Date of birth			
Public Address (Required) - Subject to Public Records Act request release*			City		Stat	e ZIP Code		
Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to address above)			ove) City		State	e ZIP Code		
Social Security Number** (SSN) or Individual Taxpayer Identification Number (ITIN)			Phone Number***	Phone Number***  Check if this is a cell phone				
4. Last Name	First Name		I	MI	Date of birth	<u>'</u>		
Public Address (Required) - Subject to Public Records Act request release*			City		State	e ZIP Code		
Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to address above)			ove) City		Stat	e ZIP Code		
Social Security Number** (SSN) or Individual Taxpayer Identification Number (ITIN)			Phone Number***		1		ck if this is	

## (ATTACH ADDITIONAL SHEETS OF THIS PAGE IF NECESSARY) First Name Last Name Date of birth City State ZIP Code Public Address (Required) - Subject to Public Records Act request release\* ZIP Code State City Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above) Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN) Phone Number\*\* Check if this is a cell phone First Name Date of birth Last Name City State ZIP Code Public Address (Required) - Subject to Public Records Act request release\* State ZIP Code Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN) Phone Number\*\*\* Check if this is a cell phone Last Name First Name MI Date of birth State ZIP Code City Public Address (Required) - Subject to Public Records Act request release\* State ZIP Code Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above) Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN) Phone Number\*\*\* Check if this is a cell phone First Name MI Date of birth Last Name City State ZIP Code Public Address (Required) - Subject to Public Records Act request release\* State ZIP Code Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above) Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN) Phone Number\*\*\* Check if this is a cell phone Date of birth First Name Last Name MΙ City State ZIP Code Public Address (Required) - Subject to Public Records Act request release\* State ZIP Code City Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above, Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN) Phone Number\*\*\* Check if this is a cell phone First Name Date of birth Last Name ΜI

\*Effective May 22, 2018, the California Department of Public Health will be required under a court order to release the address of record for certified nurse assistants, home health aides, certified hemodialysis technicians, and licensed nursing home administrators in response to a Public Records Act (PRA) request. Court Order: Service Employee International Union-United Healthcare Workers v. California Department of Public Health, Sacramento County Superior Court, February 21, 2018, No. 34-2017-8002636. \*\*If you use an invalid SSN, your application process may be delayed \*\*\*Providing your telephone number and email address is for the California Department of Public Health's internal use only for contacting applicants. This information will not be released to the public nor will it be displayed online.

City

Phone Number\*\*\*

Public Address (Required) - Subject to Public Records Act request release\*

Social Security Number\*\* (SSN) or Individual Taxpayer Identification Number (ITIN)

Confidential Address (For CDPH use only. If left blank all departmental mail will be sent to the address above)

Check if this is a cell phone

ZIP Code

ZIP Code

State

State