DC | HEALTH
Health Regulation & Licensing Administration

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HOME HEALTH AIDE ATTESTATION OF TRAINING AND COMPETENCE (ENDORSEMENT)

PART 1: To be completed by the applicant

NAME (Last, First, Middle)	Date of Birth (MM/DD/YYYY)
Social Security Number	Training Program/School's Name
Name and Address of Employer	Employer's No. and Email address

PART 2: To be completed by employer. I hereby state, to the best of my information, knowledge, and belief, the information provided in this document is true and correct. The applicant completed a training program as a Home Health Aide. He or she is competent to provide patient care and has worked a minimum of 500 hours as a Home Health Aide.

Hire Date	End date
Employer's Authorizing Rep. (Print name)	Employer's Authorizing Rep. Title
Employer's State License No.	Employer's Authorizing Rep. Signature and Date

PART 3: To be completed by the supervising nurse. I, this applicant's supervising nurse confirm that the person is competent to provide the skills in DCMR 9315.1 and 9315.2. I hereby attest that the information provided is true to the best of my knowledge. Making a false statement may result in DC HEALTH taking action that it deems appropriate.

Supervising Nurse (Print name)	Supervising Nurse License state and No.
Supervising Nurse Signature	Date