National Healthcare Workers Association
Certification Reinstatement Request Form

Instructions: *** Reinstatements are only done by mail**

Please mail this completed form with the $250 Reinstatement fee to the following Payee and address:

National Healthcare Workers Association

378 Boston Post Road Suite 1000 Orange CT 06477

***Only request for certifications that have lapsed for three (3) years or less will be considered. You will need to fill out a separate form for each certification you would like to reinstate**

Applicant Contact Information

Last Name:_____ First Name _____

Address:_____

City_____ State_____ Zip Code _____

Phone Number _____

This information will be verified by NHCWA National office

Have you worked in the field with in the last 24 months? Yes No

Have you take any continuing education in the field in the last 24 months? Yes No

Employee Name: _____

Employee Address _____

City_____ State_____ Zip Code _____

Employers Phone Number _____

Type of Credential: _____

Certification ID #: _____

Year credential expired: _____

I here by apply for reinstatement of the **NHCWA** credential and will fulfill the requirements for Reinstatement as stated in the Certification Reinstatement Policy. I acknowledge that this request is granted only.

Member Signature_____ Date _____

NHCWA Evaluation Manager Signature_____ Date _____

Request Approved ( ) Denied ( )

Reinstatement requirements must be met as outlined in the Certification Reinstatement Policy.