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Rosanna C Carrasco Espinal
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Instructions and Application For License As A Nursing Assistant

- ☒ By Examination (RI Nursing Assistant Training Program)
- ☐ By Examination (Nursing Student)

MILITARY STATUS ELIGIBILITY

(Documentation Required)
see next page for instructions

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Name:

License Number:

Have you EVER held a license as a Nursing Assistant in Rhode Island? ☐ Yes ☒ No
If Yes, please provide your RI License Number NA

Applicant - Print LEGAL Name - NAME MUST MATCH STATE ID

CARRASCO ESPINAL

ROSANNA

C

LAST NAME

FIRST NAME

MI

Phone: (401) 222-5888

TTY/TDD: (800) 745-5555



State of Rhode Island
Application for License as a Nursing Assistant

1. Name(s)	This is the name that will appear on the HEALTH website. Do not use nicknames, etc. Title (i.e., Mr., Mrs., Ms., etc.) ROSANNA First Name CAROLINA Middle Name CARRASCO ESPINAL Surname, (Last Name) Suffix (i.e., Jr., Sr., II, III) Maiden, if applicable Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).		
2. Social Security Number	037-74-2227 U.S. Social Security Number	"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State."	
3. Gender	Female	Please select from the dropdown.	
4. Date of Birth	04/26/2004 Month Day Year		
5. Home Address	It is your responsibility to notify RIDOH of all address changes within ten (10) days. 1 FL 1st Line Address (Apartment/Suite/Room Number, etc.) 45 BURROWS ST Second Line Address (Number and Street) PROVIDENCE City RI 02907 State Zip Code Country, if NOT U.S. (401) 416-1965 Home Phone FWXROSA@GMAIL.COM Email Address Home Fax		
6. Business Address (ONLY if it is RELATED to your license.)	It is your responsibility to notify HEALTH of all address changes. This address will appear on the Health website. Name of Business/Work Location 1st Line Address (Department/Suite/Room Number, etc.) Second Line Address (Number and Street) City State Zip Code Country, if NOT U.S. Postal Code, if NOT U.S. Business Phone Extension Business Fax		