THIS DOCUMENT CONTAINS A TRUE WATERMARK - HOLD UP TO LIGHT TO VIEW

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Apt 1, 11 Linton St, Providence, RI, 02908

Zonia E Aviles Guaman
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PURCHASER BY SIGNING YOU AGREE TO THE TERMS ON THE REVERSE SIDE

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License #

Rhode Island Department of Health

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For
License As A Nursing Assistant

☑ By Examination (RI Nursing Assistant Training Program)

☐ By Examination (Nursing Student)

Name: _____ *License Number:* _____

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

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

AVILES GUAMAN	ZONIA	E
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.)

ZONIA

First Name

ELIZABETH

Middle Name

AVILES GUAMAN

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

729-10-5001

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 Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

Female

Please select from the dropdown.

4. Date of Birth

04/13/1983

Month Day Year

5. Home Address

It is your responsibility to notify RIDOH of all address changes within ten (10) days.

APT 1

1st Line Address (Apartment/Suite/Room Number, etc.)

11 LINTON ST

Second Line Address (Number and Street)

PROVIDENCE

City

RI

State

02908

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

(401) 696-1853

Home Phone

Home Fax

ZONIAAVILES13@GMAIL.COM

Email Address

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