Washington State Department of Health
Washington State Board of Nursing
P.O. Box 1099
Olympia, WA 98507-1099

Application Fee $5.00
Make Check Payable to Department of Health

APPLICATION FOR CERTIFICATION AS A NURSING ASSISTANT

PLEASE TYPE OR PRINT CLEARLY

Applicant's Name (20) VAUGHN (LAST) EVETT (FIRST) A (MIDDLE INITIAL) ——— (MAIDEN)

Home Address (21) E. 13811 46th

City (24) Spokane State (25) WA ZIP (26) 99216 County (27) Spokane

Telephone No. (39) (509) 922-9448
ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.

Sex (F or M) F Date of Birth 4 - 16 - 76 (MONTH DAY YEAR)

Social Security Number (40) 1 - DOH Licensee Social Security Number - RCW 42.56.35...
REQUESTED FOR IDENTIFICATION PURPOSES ONLY. ENTERING SSN IS VOLUNTARY AND NOT REQUIRED FOR CERTIFICATION APPROVAL.

FOR OFFICE USE ONLY	
CERT DATE (44)	052595
CERT NO. (45)	348147 042295

Training Site The Gardens (NAME OF APPROVED PROGRAM) Spokane, WA (LOCATION (CITY, STATE)) Completion Date 3 - 3 - 95 (MONTH DAY YEAR)

EMPLOYMENT IN PREVIOUS 24 MONTHS (List all, use extra sheets if necessary)

NAME	LOCATION	DATE HIRED	DATE LEFT	TITLE
1. Current		C		
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PERSONAL DATA

All health and health related professions credentialed by the state of Washington are regulated under the Uniform Disciplinary Act.

	Yes	No
1. Within the past ten years, have you been convicted of a felony or misdemeanor?	☐	☒
2. Within the past ten years, have you been named in a civil suit related to your profession or occupation?	☐	☒
3. Within the past ten years, has your professional or occupational registration, certification or license been suspended, revoked, restricted or denied in any state or country?	☐	☒
4. Within the past five years, have you used drugs or alcohol in an addictive manner, have you been chemically dependent, or have you been treated for chemical dependency?	☐	☒
5. Do you have, or have you in the past five years been diagnosed as having or been hospitalized for a psychiatric condition; or do you have, or have you in the past five years been diagnosed as having or been hospitalized for any other mental condition that significantly impaired your ability to function?	☐	☒
6. Do you have, or have you in the past five years been diagnosed as having a physical or medical condition which may result in your being unable to practice with reasonable skill and safety?	☐	☒
7. Have you been known by any other name?	☐	☒

LIST _____

For each YES answer to questions 1 through 6, please submit a detailed written explanation on a separate sheet of paper. Additional documentation required is outlined in the Instructions For Nursing Assistant Certification. Failure to provide complete information may delay your certification.

AFFIDAVIT (To be completed by applicant)

I, VAUGHN EVETT ANN, certify that I am the person described
TYPE OR PRINT FULL NAME OF APPLICANT

and identified in this application, and that I have answered all questions in this application truthfully and completely. I understand that the Department may require additional information from me prior to making a determination regarding my application. I also understand that if I provide false or incomplete information, my application may be denied.

Evett Ann Vaughn
APPLICANT'S SIGNATURE

3-1-95
DATE OF APPLICATION

ATTESTATION (To be completed by Program Director)

I certify that EVETT ANN VAUGHN, has successfully completed the approved
TYPE OR PRINT FULL NAME OF APPLICANT

nursing assistant program at THE GARDENS on 3-3-1995
NAME OF FACILITY/SCHOOL MONTH, DAY, YEAR

program code 1A240

A. Bernadine Tichelaar RN
SIGNATURE

Program Director
TITLE

Washington State Department of Health
Washington State Board of Nursing
PO Box 47864
Olympia, Wa 98504-7864
(206) 586-1923

CERTIFICATION OF COMPLETION
AIDS EDUCATION AND TRAINING

APPLICANT: Please complete the form below in full and return to:

Department of Health
Washington State Board of Nursing
PO Box 47864
Olympia, WA 98504-7864

PLEASE PRINT OR TYPE
Applicant Name VAUGHN (LAST) EVETT (FIRST) ANN (MIDDLE)

Street Address E. 13811 46th

City Spokane State WA ZIP 99216

Date of Birth 4-16-76 Social Security Number 1 - DOH Licensee Social Security Number - RCW 42.56.3...

Profession **NURSING ASSISTANT** ☒ **REGISTERED** ☐ **CERTIFIED**
PLEASE CHECK ONE

I certify that I have received 7 hours of AIDS education and training through Valley Crest
ORGANIZATION, COLLEGE, ETC.

on 2-17-95
MONTH / DAY / YEAR

which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

Evett Ann Vaughn 3-1-95
SIGNATURE DATE

Washington State Department of Health
Washington State Board of Nursing
PO Box 47864
Olympia, WA 98504-7864
(206) 586-1923

NOTICE
AIDS EDUCATION REQUIREMENTS
FOR HEALTH RELATED PROFESSIONS

The Department of Health has been charged with implementing the mandatory AIDS training and education as passed by the 1988 legislature, The Omnibus AIDS Bill (ESSB 6221). All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected.

Beginning on January 1, 1989, new applicants in the health related professions were required to provide certification of having met the minimum contact hours in specific topics.

Professions which come in contact with body fluids known to transmit AIDS are required to have a minimum of 7 contact hours of education in the following six topics: Etiology and Epidemiology of HIV, Transmission and Infection Control, Testing and Counseling, Clinical manifestations and Treatment, Legal and Ethical Issues to Include Confidentiality and Psychosocial Issues to Include Special Population Considerations.

Yours is one of those professions.

The Department will accept courses taken since January 1, 1987 which fulfill the requirements of hours and topics listed above.

This requirement is considered as one of the qualifying prerequisites to licensing and an application is considered to be incomplete until documentation is provided.

If you have any questions regarding this requirement, please call the number shown on the general application instructions or write to:

Department of Health
Washington State Board of Nursing
PO Box 47864
Olympia, WA 98504-7864

Washington State Department of Health

5. —

NURSING ASSISTANTS-CERTIFIED

REVENUE SECTION

PRINT NAME Vaughn, Evett A

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0299030000 00560

Application File_42096_pdf-r.pdf redacted on: Thursday, December 06, 2012

Redaction Summary (2 redactions)

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1 Privilege / Exemption reason used:

1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (2 instances)

Redacted pages:

Page 1, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
Page 3, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance