**Attestation for Documentation of Temporary Nurse Aide Work Experience**

Date: Click or tap to enter a date.

To: SCDHHS

via email: SCNAR@scdhhs.gov

Provider Name\*:Click or tap here to enter text.

Provider Medicaid ID\*:Click or tap here to enter text. **(Six-digit legacy ID)**

Provider NPI: Click or tap here to enter text.  
\*Required fields

**Please submit a separate form for each Provider Medicaid ID.**

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|  | **Cna365 Candidate ID #** | **First/Last Name** | **DOB** | **Last 4 SSN** | **60-hour State-approved Nurse Aide Training Program Name and Completion Date** | **8-hour TNA Completion**  **date** | **Dates Employed** |
|  |  |  |  |  |  | **OR** |  |
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By signing below, I verify the attached roster of temporary nurse aide staff meet the training and experience requirements outlined in the May 18, 2022, Medicaid bulletin, [MB# 22-006](https://www.scdhhs.gov/press-release/covid-19-temporary-policy-updates-nurse-aide-training-and-competency-evaluation-and). Providers with multiple Medicaid IDs are required to submit an attestation for each ID.

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Printed Name of Provider’s Authorized Representative

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Title of Provider’s Authorized Representative

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Signature of Provider’s Authorized Representative

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Date