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VERIFICATION OF LICENSED HEALTH AIDE CARE

Instructions: This form must be completed by a Registered Nurse to certify the continued competence of a Licensed Health Aide. This completed document must be submitted directly from the program/agency to the Arizona State Board of Nursing via email at LHA@azbn.gov.

LICENSED HEALTH AIDE (LHA) INFORMATION

Full Name: _____

LHA License Number: _____ **Last 4 Digits of SSN:** _____

CERTIFICATION OF COMPETENCE

In accordance with R4-19-904(C)(3)

I certify that the Licensed Health Aide provider named above has adequately maintained the skills and knowledge required for the safe care of the patient.

Name of Registered Nurse: _____

RN License Number: _____

Date of Deemed Competence: _____

RN Signature: _____ **Date:** _____

AGENCY / PROGRAM INFORMATION

Home Care Company Name: _____

Contact Email/Phone: _____