



COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH PROFESSIONS LICENSURE
BOARD OF CERTIFICATION OF COMMUNITY HEALTH WORKERS
www.mass.gov/dph/boards
(617)973-0800 or (800)414-0168

Community Health Worker (CHW) Certification Application

HOW TO APPLY

1. Complete the following sections:

- Part A: Applicant Information
- Part B: Work Experience as a CHW
- Part C: Training and Work Experience Pathway applicants ONLY
- Part D: Reference Information
- Part E: Other Licenses or Certifications (if applicable)
- Part F: Release & Affidavit of Applicant

2. Complete additional required information:

- Three (3) completed and signed reference forms in individual, sealed and signed envelopes.
- Be sure to sign the completed application on page 10 with a notary and attach a 2x2 passport photo.
- All applicants must submit their Social Security number (see page 10).
- ALL applicants must submit the signed and notarized Criminal Offender Record Information (CORI) Acknowledgement Form at the end of this application.
- Include a nonrefundable \$35 application fee, as a check or money order payable to Commonwealth of Massachusetts. (NOTE: If you are applying online, you can make your payment online).
- If you hold a professional license or certification issued by a state or national board, you must submit either verification of that license from the board that issued it, OR a copy of your license or certification (See page 7).
- If you are a licensed health care provider, you must include a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query Report. (See page 7).
- Mail all materials (printed on single-sided paper) in one envelope to:

**Board of Certification of Community Health Workers
239 Causeway Street, Boston, MA 02114**

You must provide all required documents. If your application packet is incomplete, it will be returned to you. Be sure to keep a copy of your completed application and all materials you have submitted for your records.

Answers to frequently asked questions (FAQs) are on the Board's website (www.mass.gov/dph/boards). Statutes and regulations about CHW certification are also on the website; they can also be purchased from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

PART A. APPLICANT INFORMATION

First Name	Middle Name	Last Name
Current Address		
(Number & Street)	(Apt #)	(City/Town) (State) (Zip Code)
Most Recent Previous Address		
(Number & Street)	(Apt #)	(City/Town) (State) (Zip Code)
Telephone – Preferred	Telephone – Alternate	Preferred Email
Date of Birth (MM/DD/YYYY)	Birthplace (City, State, Country)	
Social Security Number	Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	Mother's Maiden Name
Height (Feet, inches)	Weight	Eye Color

Preferred Language (in case we need to contact you):

The Board is very committed to the diversity of the CHW workforce. The following demographic questions are asked as part of an effort to understand the impact of certification. The aggregate information will be used for data purposes only to document overall demographics of certified CHWs in Massachusetts, and will not impact eligibility.

Are you of Hispanic or Latino origin or descent?
 Yes, Hispanic or Latino
 No, not Hispanic or Latino
 Decline to answer

What is the "race" that you most identify with? (Check all that apply)
 White
 Black or African-American
 Asian
 Native Hawaiian or other Pacific Islander
 American Indian or Alaska Native
 Other (Please specify _____)
 Decline to answer

What ethnicity do you most identify with? Ethnicity refers to your background, heritage, culture, ancestry, or sometimes the country where you or your family were born. Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> African | <input type="checkbox"/> Guatemalan |
| <input type="checkbox"/> African American | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> American | <input type="checkbox"/> Honduran |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Brazilian | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Cape Verdean | <input type="checkbox"/> Mexican, Chicano |
| <input type="checkbox"/> Caribbean Islander | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Colombian | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Dominican | <input type="checkbox"/> Salvadoran |
| <input type="checkbox"/> European | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Decline to answer |

FOR BOARD USE ONLY

Application Processing Date: _____ Staff initials: _____

Application Number: _____ Receipt Number: _____

Certification Number: _____

PART B. CHW WORK EXPERIENCE

Please check one:

- I am applying through the **Training and Work Experience Pathway**. Below I will document at least 2,000 hours of CHW work from the past 10 years.
- I am applying through the **Work Experience Pathway**. Below I will document at least 4,000 hours of CHW work from the past 10 years.

Instructions: Please list your job experience as a CHW. **In order for your job experience to be counted toward the required number of hours, it must fit within the scope of practice for CHWs.** If you are unsure about a job, please refer to the CHW Scope of Practice (link).

- Both paid and unpaid work may count toward work experience hours. If you completed unpaid work and did not have a job title, you may list “Volunteer” or “Intern” in the **Job Titles** box.
- **Total Hours** should be the total the number of hours you worked while you held the position. For example, if you worked 40 hours a week for 6 months (or 24 weeks), you would list “960” hours (24 weeks x 40 hours = 960 hours). Only include time where your job duties fit within the CHW scope of practice. For example, if you worked 40 hours a week for 6 months at an organization, but 20 hours of your work each week was not CHW work, you would only list 480 hours (24 weeks x 20 hours = 480 hours).
- If you need more space, submit copies of the next page.

POSITION 1. (MOST RECENT OR CURRENT)		
Organization Name & Address	Job Title(s)	Type of Work
		<input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Internship/Practicum
Dates Worked (Month/Year)		Total Hours CHW Work
Start: End:		
Supervisor or Individual Who Can Verify Your Work Experience	Job Duties (check all that apply)	
Name: Phone Number: Position:	<input type="checkbox"/> Health education <input type="checkbox"/> Coordinating care including referrals <input type="checkbox"/> Informal support and/or counseling <input type="checkbox"/> Advocacy for individuals and/or communities <input type="checkbox"/> Community or individual needs assessment <input type="checkbox"/> Activities to increase community and/or individual capacity <input type="checkbox"/> Disease prevention and management <input type="checkbox"/> Outreach <input type="checkbox"/> Other (Explain) _____	

POSITION 2.

Organization Name & Address	Job Title(s)	Type of Work
		<input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Internship/Practicum
Dates Worked (Month/Year)		Total Hours CHW Work
Start:		
End:		
Supervisor or Individual Who Can Verify Your Work Experience	Job Duties (check all that apply)	
Name:	<input type="checkbox"/> Health education <input type="checkbox"/> Coordinating care including referrals <input type="checkbox"/> Informal support and/or counseling <input type="checkbox"/> Advocacy for individuals and/or communities <input type="checkbox"/> Community or individual needs assessment <input type="checkbox"/> Activities to increase community and/or individual capacity <input type="checkbox"/> Disease prevention and management <input type="checkbox"/> Outreach <input type="checkbox"/> Other (Explain)_____	
Phone Number:		
Position:		

POSITION 3.

Organization Name & Address	Job Title(s)	Type of Work
		<input type="checkbox"/> Paid <input type="checkbox"/> Unpaid <input type="checkbox"/> Internship/Practicum
Dates Worked (Month/Year)		Total Hours CHW Work
Start:		
End:		
Supervisor or Individual Who Can Verify Your Work Experience	Job Duties (check all that apply)	
Name:	<input type="checkbox"/> Health education <input type="checkbox"/> Coordinating care including referrals <input type="checkbox"/> Informal support and/or counseling <input type="checkbox"/> Advocacy for individuals and/or communities <input type="checkbox"/> Community or individual needs assessment <input type="checkbox"/> Activities to increase community and/or individual capacity <input type="checkbox"/> Disease prevention and management <input type="checkbox"/> Outreach <input type="checkbox"/> Other (Explain)_____	
Phone Number:		
Position:		

DRAFT

Community Health Work Total Hours: _____ Staff Initials: _____

DRAFT

PART C. FOR TRAINING AND WORK EXPERIENCE PATHWAY APPLICANTS

(If you are applying through the Work Experience only Pathway, SKIP to Part D).

Training and Work Experience Pathway applicants must complete an Approved Core Competency Training Program (approved by the Massachusetts Board of Certification of CHWs). A list of approved training programs is available at [link]. Please list the approved training program that you've completed.

Training Program Provider/Organization:
Training Course or Program Name:
Location of Training Program (City/Town):
Date of Completion (MM/YYYY):

Please enclose verification of training completion in an envelope sealed and signed by the Approved Training Program where you completed your CHW core competency training.

PART D. PROFESSIONAL REFERENCES

As part of your application, you are required to submit three (3) professional references. Your references should be people who are familiar with your CHW work experience and are able to rate you in the Core Competencies. References cannot be a spouse, partner, family member, or a current or past patient or client. More detailed instructions are on the Reference Form (link). Three (3) copies of the form must be printed out, and given to your references to fill out. The completed forms must be included in your application, in envelopes individually sealed and signed by your references.

List your three professional references:

Reference 1 Name:	
Position/Title:	Organization:
Reference 2 Name:	
Position/Title:	Organization:
Reference 3 Name:	
Position/Title:	Organization:

PART E. OTHER LICENSES OR CERTIFICATIONS

Check here if you don't currently have and have never had any professional license or certification, and SKIP to Part F.

If you have ever held any of the following professional licenses or board certifications, list them below: Registered Nurse, Licensed Social Worker, Emergency Medical Technician, Medical Assistant, Certified Nurse's Assistant, or Medical Doctor. List even those that have expired or been revoked, in any state or jurisdiction. Do not include professional licenses and certifications issued in other countries.

<u>Issuing State/Jurisdiction</u>	<u>Profession</u>	<u>License/Certification Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been certified as a CHW in any other state? (In example: Texas, New Mexico, Ohio, or Oregon)

- Yes If yes, please list state: _____
 No

NOTE: If your license or certification was issued by a board that will verify it, please obtain a letter of verification of your license or certification from that board, and submit it with your application. If your license or certification was not issued by a state or national board, please send a copy of your license or certification.

NOTE: If you now hold, or have ever held, any professional license as Registered Nurse, Licensed Social Worker, Emergency Medical Technician, Medical Assistant, Certified Nurse's Assistant, or Medical Doctor in the United States, you must also request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query Report (original copy) with your application. To request this, please contact the National Practitioner Data Bank at 1-800-767-6732 or at www.npdb-hipdb.hrsa.gov.

Please answer the following questions. If you answer "YES" to any of them, please attach a separate sheet explaining the circumstances. Each application will be reviewed on a case-by-case basis.

1. Have you ever been denied a professional license, or ever withdrawn or attempted to withdraw an application, for any professional license in the United States, or in any country or foreign jurisdiction?
 Yes No
2. Has any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?
 Yes No

3. Are you the subject of any pending disciplinary action by any licensing or certification board, government authority, hospital or health care facility or professional association located in the United States or any country or foreign jurisdiction?

Yes No

4. Have you ever voluntarily surrendered or resigned any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes No

PART F. RELEASE & AFFIDAVIT OF APPLICATION

Complete the following release and affidavit with a notary. Initial each statement and sign the form.

____ I hereby authorize all hospitals, institutions, credentialing agencies, organizations, employers (past and present), business and professional associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Board of Certification of Community Health Workers any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board of Certification of Community Health Workers to release information contained in this application in association with its processing.

____ To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and I do not owe child support.

____ I understand that I am responsible for reading and understanding the laws and regulations governing certification as a Community Health Worker in Massachusetts and I hereby agree to comply with such laws and regulations.

____ I have read the Professional and Ethical Standards of Conduct for Certified Community Health Workers (below):

272 CMR 8.00: PROFESSIONAL AND ETHICAL STANDARDS OF CONDUCT FOR CERTIFIED COMMUNITY HEALTH WORKERS

8.01: Purpose

272 CMR 8.00 defines the standards of conduct for all Certified Community Health Workers certified by the Board of Certification of Community Health Workers.

8.02: Standards of Conduct for Certified Community Health Workers

The Standards of Conduct for Certified Community Health Workers include:

- (1) **Use of Title.** A Certified Community Health Worker shall only identify himself or herself as a Certified Community Health Worker while in the possession of a current certification;
- (2) **Misrepresentation of Credentials.** A Certified Community Health Worker shall not misrepresent his or her credentials related to the practice of community health work including, but not limited to, those indicating education, type of community health worker certification, professional experience, or any other credential related to his or her work as a community health worker.
- (3) **Practice Under a False or Different Name.** A Certified Community Health Worker shall engage in the practice of community health work only under the name in which such certification has been issued.
- (4) **Acts within Scope of Practice.** A Certified Community Health Worker shall only perform acts within the scope of community health worker practice as defined in M.G.L. c. 112, § 259 and 272 CMR 6.01.
- (5) **Competency.** A Certified Community Health Worker shall only assume those duties and responsibilities within his or her scope of practice and for which he or she has acquired and maintained necessary knowledge, skills, and abilities.
- (6) **Responsibility and Accountability.** A Certified Community Health Worker shall be responsible and accountable for his or her judgments, actions, and competency in the course of performing his or her duties as a Certified Community Health Worker.
- (7) **Documentation.** A Certified Community Health Worker shall make complete, accurate, and legible entries in all records required by federal, state and local laws and regulations.

- (8) Falsification of Information. A Certified Community Health Worker shall not knowingly falsify, or attempt to falsify, any documentation or information related to any aspect of certification as a community health worker, the practice of community health work, or the delivery of community health worker services.
- (9) Alteration or Destruction of Records. A Certified Community Health Worker shall not inappropriately destroy or alter any record related to his or her work as a Certified Community Health Worker.
- (10) Discrimination. A Certified Community Health Worker shall not withhold or deny care or services based on age, ancestry, marital status, sex, sexual orientation, gender identity, race, color, religious creed, national origin, diagnosis, or mental or physical disability.
- (11) Client Abuse, Neglect, Mistreatment, or Other Harm. A Certified Community Health Worker shall not abuse, neglect, mistreat, or otherwise harm a client.
- (12) Infection Control. A Certified Community Health Worker shall not place a client, himself or herself, or others at undue risk for the transmission of infectious diseases.
- (13) Client Dignity and Privacy. A Certified Community Health Worker shall safeguard a client's dignity and right to privacy.
- (14) Client Confidential Information. A Certified Community Health Worker shall safeguard client information from any person or entity, or both, not entitled to such information. A Certified Community Health Worker shall share appropriate information only as required by law or authorized by the client for the well-being or protection of the client.
- (15) Sexual Contact. A Certified Community Health Worker shall not have sexual contact with any client with whom he or she has a current community health worker/client relationship or with any former client who may be vulnerable by virtue of disability, age, illness, or cognitive ability.
- (16) Professional Boundaries. A Certified Community Health Worker shall establish and observe professional boundaries with respect to any client with whom he or she has a current community health worker/client relationship. A Certified Community Health Worker shall continue to observe professional boundaries with his or her former clients who may be vulnerable by virtue of disability, age, illness, or cognitive ability.
- (17) Exercise of Undue Influence. A Certified Community Health Worker shall not exercise undue influence on a client, including the promotion or sale of services, goods, appliances or drugs, in such a manner as to exploit the client for financial gain of the Certified Community Health Worker or third party.
- (18) Borrowing from Clients. A Certified Community Health Worker shall not borrow money, materials, or other property from any client.
- (19) Undue Benefit or Gain. A Certified Community Health Worker shall interact with clients without undue benefit or gain to the Certified Community Health Worker or third party.
- (20) Relationship Affecting Professional Judgment. A Certified Community Health Worker shall not initiate or maintain a community health worker/client relationship that is likely to adversely affect the community health worker's professional judgment.
- (21) Advertising. A Certified Community Health Worker shall not engage in false, deceptive, or misleading advertising related to community health work.
- (22) Fraudulent Practices. A Certified Community Health Worker shall not engage in any fraudulent practice including, but not limited to, billing for services not rendered or submitting false claims for reimbursement.
- (23) Impersonation. A Certified Community Health Worker shall not impersonate another community health worker or other health care provider, or knowingly allow or enable another person to impersonate him or her.
- (24) Aiding Unlawful Activity. A Certified Community Health Worker shall not aid any person in performing any act prohibited by law or regulation.
- (25) Circumvention of Law. A Certified Community Health Worker shall not receive from, or offer, give, or promise anything of value or benefit to, any official to circumvent any federal, state and local laws and regulations.
- (26) Practice While Impaired. A Certified Community Health Worker shall not act as a community health worker while impaired.
- (27) Unlawful Acquisition and Possession of Controlled Substances. A Certified Community Health Worker shall not unlawfully obtain or possess controlled substances.
- (28) Duty to Report to the Board. A Certified Community Health Worker who directly observes another community health worker or health care professional engaged in any of the following shall report that

individual to the Board: (a) abuse of a client; (b) practice of community health work while impaired by substance use; (c) diversion of controlled substances.
(29) Violence. A Certified Community Health Worker shall not endanger the safety of the public, clients, or coworkers by making actual or implied threats of violence, or carrying out an act of violence.
(30) Compliance with Agreements and Orders. A Certified Community Health Worker shall comply with all provisions contained: (a) in any agreement he or she has entered into with the Board; or (b) in any order issued to him or her by the Board.

Please also initial the following statement:

____ I certify, to the best of my knowledge, that the information I have provided for this application for certification and all supporting documents is truthful and accurate. I understand that any failure to provide truthful and accurate information in this application for certification may be grounds for the Board of Certification for Community Health Workers to deny issuing certification to me; to suspend or revoke a certification issued to me; or to deny renewal of a certification issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

NOTARY NAME: _____

COMMISSION EXPIRES: _____
[Seal]

**Attach a recent color
2x2 passport
photo**

INCLUDE A NONREFUNDABLE, NONTRANSFERABLE FEE OF \$35 (CHECK OR MONEY ORDER), PAYABLE TO THE "COMMONWEALTH OF MASSACHUSETTS"

What We Do with Your Social Security Information

According to General Law. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue. **The Department of Revenue will use your SSN to determine whether or not you are in compliance with Massachusetts tax laws (G.L. c. 62C, s. 47A) and child support laws (G.L. c. 119A, s.16).**

Important Information about Change of Address or Name

Community Health Workers (both applicants and already certified CHWs) must notify the Board in writing of any changes in address or name within thirty (30) days after the change.

To be sure you receive materials about certification renewal and other information, it's important that you update your address with the Board.

Once you are certified, your address will be available to anyone who requests it, as it is a public record. If you are using your home address, you may consider using a work address instead. You can change your address online at the Board's website, www.mass.gov/dph/boards, or you can get a form online to submit to the Board.

ADDITIONAL REQUIRED INFORMATION

Please answer the two questions below. If you answer "YES" to any of them, please attach a separate sheet explaining the circumstances and any evidence of your rehabilitation efforts, such as participation in education programs and training, addiction treatment, community contributions and/or volunteer work, and evidence of work history. Work history can include, but is not limited to, evidence of past successful work as a Community Health Worker, employment and/or character references. The Board will strongly consider the social conditions and/or extenuating circumstances which may have contributed to the crime, actions since offense and how those actions are consistent with a position of public trust. **Each application will be reviewed on a case-by-case basis. There will be no blanket or automatic exclusions.**

1. Have you ever been court martialled or other than honorably discharged from the armed services (military) of the United States or of any country or foreign jurisdiction?

Yes No

2. Have you ever been convicted or do you have any open case(s) at the present time? Please do not send information about arrests that did not lead to convictions, juvenile offenses, or sealed items. Do not list misdemeanors more than five years old.

Yes No

The Criminal Offender Record Information (CORI)

CORI is the last piece of the application process and is only completed after the applicant meets all other criteria for Certification.

- The Board will consider **only convictions and open cases.**
- The Board will **not see or consider arrests, juvenile offenses, or sealed items.**
- There will be **no automatic disqualifications.**
- In evaluating CORI, the Board will **strongly consider mitigating circumstances and evidence of rehabilitation efforts,** such as education and training, addictions treatment, and evidence of work history, including volunteer work.

The Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data.

Print out the Criminal Offender Record Information (CORI) Acknowledgement Form available at the end of this application and include the signed, notarized form with your application.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Certification of Community Health Workers
239 Causeway Street, Suite 500
Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0806

Fax: 617-973-0980

www.mass.gov/dph/boards/chw

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

**CRIMINAL OFFENDER RECORD INFORMATION
(CORI) ACKNOWLEDGEMENT FORM**

**TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT,
VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.**

The Board of Certification of Community Health Workers is registered under the provisions of M.G.L. c. 6, §172 to receive CORI for the purpose of screening current and otherwise qualified certification applicants and current certificate holders.

As a prospective certification applicant or current certificate holder, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Certification of Community Health Workers to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND CERTIFICATION PURPOSES ONLY:

The Board of Certification of Community Health Workers may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Certification of Community Health Workers must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE

DATE

NOTE: The Board of Certification of Community Health Workers cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a BHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION
(CORI) ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

The identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

VERIFIED BY: _____ ON: _____
Name of Verifying BHPL Employee or Notary Public (Please Print) (Date)



COMMUNITY HEALTH WORKER CERTIFICATION APPLICATION PACKET CHECKLIST

The items on this checklist must be included for an application to be complete.

**Please complete and include this checklist with your application.
The Board will not review applications until all of the required documents have been received.**

Required for ALL Applicants

- Pages 3-11 completed on single-sided paper.
- Page 10 signed and **notarized**.
- Three (3) completed reference forms printed on single-sided paper, each in individual envelopes sealed and signed by the reference over the envelope seal.
- 2" x 2" Passport style photo attached to signature page (page 10).
- Signed and **notarized** Criminal Offender Record Information (CORI) Acknowledgement Form (pp. 12-13).
- Application Fee of \$35. If unable to pay online, this must be a check or money order payable to the *Commonwealth of Massachusetts*. Fees are nonrefundable and nontransferable. Fees can only be used for your certification application.

Check ONE

- I have enclosed verification of training completion in an envelope sealed and signed by the Approved Training Program where I completed my CHW core competency training.
- OR**
- I am applying through the Work Experience Pathway, and I do not need to submit information about the training programs I have completed.

Check ONE

- I now hold, or I have previously held, a professional license or certification as a Registered Nurse, Licensed Social Worker, Emergency Medical Technician, Medical Assistant, Certified Nurse's Assistant, or Medical Doctor, and I have included either a letter of verification from the issuing board **OR** a copy of the license or certification.
- OR**
- I have never held such a professional license or certification.

Check ONE

- I now hold, or I have previously held, a professional license as a Registered Nurse, Licensed Social Worker, Emergency Medical Technician, Medical Assistant, Certified Nurse's Assistant, or Medical Doctor, and I have included a copy of my National Practitioner Data Bank- Healthcare Integrity and Protection Data Bank Self-Query Report.
- OR**
- I have never held such a professional license in healthcare.

Please keep a copy of all materials you have submitted for your records.