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
250 WASHINGTON STREET, BOSTON, MA 02108
(617) 973-0806
(617) 973-0980 FAX

INSTRUCTIONS AND CHECKLIST APPLICATION FOR REACTIVATION OF COMMUNITY HEALTH WORKER CERTIFICATION

Please read these instructions carefully. All supporting materials must be submitted at the same time. Applications will not be reviewed by the Board until all documentation has been received.

All requested information must be provided; failure to provide requested information may result in a delay in processing of application. Incomplete applications will be returned to applicant.

NOTICE:
Upon Board review of the reactivation application and related documents, the Board may request that additional documentation be submitted.

Complete reactivation applications must include the following documents:

☐ Completed application form with a 2x2 passport-style color photo **and notary signature**.

☐ Submission of the **notarized** Criminal Offender Record Information Request Form (CORI).

☐ Documentation of compliance with the Board's Continuing Education requirement. A minimum of 15 CEUs for the most recently completed CEU cycle are required.
CEU renewal cycles begin July 31, odd year and end July 30, next odd year.
NOTE: certificate holders are exempt from completing CEUs for the 2021-2023 renewal cycle.

☐ If you hold, or have ever held, any professional license or certification, you must request and submit a National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank Self-Query. To request a Self- Query, please contact the National Practitioner Data Bank at 1-800-767-6732 or at www.npdb-hipdb.com. Include the **ORIGINAL** results with this application; keep a copy for your records.

☐ Check or money order payable to the Commonwealth of Massachusetts. Cash or foreign currency is not accepted.

☐ Submission of completed reactivation application and fee acknowledges that the licensee understands and agrees to all provisions herein. Reactivation applications are void if requirements for reactivation of a Community Health Worker Certification license are not met within one (1) year from the date of Board receipt of this reactivation application. **All fees are non-refundable and non-transferable.**

☐ Reactivation application must be submitted on single-sided paper.

☐ Retain a copy of the completed reactivation application and related documents for your records.

IMPORTANT INFORMATION

Community Health Worker applicants for certification reactivation must notify the Board in writing of any changes in the applicant's information within thirty (30) days of their occurrence, including but not limited to any change of address and any name change.

A reactivation application is no longer valid if requirements for reactivation of a Community Health Worker Certification are not met within one (1) year from the date of Board receipt. All fees are non-refundable and non-transferable.

The address printed on your license is a **PUBLIC RECORD** that is available to anyone who requests it. Address changes may be done online at the Board's website www.mass.gov/dph/boards or you may obtain a form online to submit to the Board's office.

Failure to update your address may result in failure to receive a license renewal application and expiration of your license.

The address of record is where the Board mails your license and any correspondence.

Retain a copy the completed reactivation application and all related documents for your records. Employers may require that you provide them with a copy.

Answers to many questions about Community Health Worker certification may be found on the website; they are also available for purchase from the State House Bookstore, Massachusetts State House, Room 116, Boston, MA 02108, 617-727-2834.

For further information, please contact the Board office at 1-800-414-0168.

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BOARD OF CERTIFICATION OF COMMUNITY HEALTH WORKERS
250 WASHINGTON STREET, BOSTON, MA 02108
BOSTON, MA 02114
800-414-0168
617-973-0806
www.mass.gov/dph/boards

All Questions Must Be Answered

REACTIVATION APPLICATION FOR COMMUNITY HEALTH WORKER CERTIFICATION

NOTE: ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE.

1. NAME:_____ **CERTIFICATE NO.:**_____ **REACTIVATION FEE: $92.00**_____

a. MAIDEN/OTHER NAME: _____
(if applicable) Last First Middle

2. ADDRESS OF RECORD: _____ _____
No. Street Apt. #

_____
City/Town State Zip Code

3. MOST RECENT PREVIOUS ADDRESS: _____
(Must Be Different than Current Address) No. Street Apt. #

_____
City/Town State Zip Code

4. TELEPHONE NUMBER(S) Day: _____ Evening: _____ Cell: _____

5. _____/_____/_____ _____
Date of Birth (mm/dd/yyyy) **Place of Birth** (city/state/country)

HEIGHT: ____ Feet ____ Inches **WEIGHT**: _____ Lbs. **EYE COLOR**:_____

MOTHER'S MAIDEN NAME: _____

Email Address: _____

6. **SOCIAL SECURITY NUMBER (SSN) (disclosure is mandatory):**_____/_____/_____
Pursuant to G.L. c. 30A, s. 13A and G.L. 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 ascertain 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).

FOR BOARD USE ONLY

Application Number:_____ Receipt Number: _____

VERIFICATION OF OTHER LICENSES/ BOARD CERTIFICATIONS

7. LIST BELOW ALL OTHER PROFESSIONAL LICENSES AND BOARD CERTIFICATIONS YOU HOLD/HELD IN OTHER JURISDICTIONS:

☐ I **DO NOT CURRENTLY HOLD AND HAVE NEVER HELD ANY PROFESSIONAL LICENSE OR CERTIFICATION IN ANY STATE OR JURISDICTION.**

Issuing State/Jurisdiction	Profession	License/Certification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicants must arrange for official documentation of current license status from each state or jurisdiction to be mailed directly to the Board in a signed, sealed envelope.

QUESTIONS

IF YOU ANSWER "YES" TO QUESTION 1-6 OF THE FOLLOWING QUESTIONS PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES.

1. Have you ever been denied a license, or a certification or ever withdrawn or attempted to withdraw an application, for any professional license in the United States or 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 ☐

5. Have you ever been convicted of a crime or do you have any open criminal case(s) at the present time. Please do not send information about arrest(s) that did not lead to convictions, juvenile offenses, or sealed items. Do not list misdemeanor more than five years old.

Yes ☐ No ☐

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

Yes ☐ No ☐

7. Since the expiration of your certification, have you completed 15 contact hours of qualified continuing education activities. (Please note, certificate holders are exempt from completing CEUs for the 2019-2021 renewal cycle.)

Yes ☐ No ☐

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, 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 reactivation application. I further authorize the Board of Certification of Community Health Workers to release information contained in this reactivation application in association with its processing.

AFFIDAVIT OF APPLICANT

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 do not owe child support.

I understand that 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. As an applicant for reactivation of my license to practice as a Community Health Worker, I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

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

I understand that this reactivation application for licensure as a Community Health Worker shall be deemed no longer valid if requirements for reactivation of my licensure as a Community Health Worker are not met within one (1) year from the date of Board receipt. I also understand that fees are non-refundable and non-transferable.

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this reactivation application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for reactivation of my Community Health Worker Certification may be grounds for the Board of Certification of Community Health Workers to deny reactivation of my license; to suspend or revoke a license issued to me; and to deny renewal of a license issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent passport photo (2x2) (Not Actual Size)

NOTARY NAME**:** _____

COMMISSION EXPIRES: _____ [Seal]

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment or licensing purposes.

The Bureau of Health Professions Licensure is registered under the provisions of M.G.L. c.6, §172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Bureau of Health Professions Licensure 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 the Bureau of Health Professions Licensure with written notice of my intent to withdraw consent to a CORI check.

I also understand that the Bureau of Health Professions Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me.

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

_____ _____

Signature of CORI Subject *Date*

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____

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

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

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION (Complete only if signed by BHPL staff)

*The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____

Print Name of Verifying BHPL Employee

_____ _____

Signature of Verifying BHPL Employee *Date*

Authentication of Signature
Please note that ALL fields in this section must be completed by the Notary Public. Evidence of identification must be government issued photo ID.

On this ____ day of _____ , 20___, before me, the undersigned notary public, _____ (name of applicant) personally appeared, proved to me through satisfactory evidence of identification, which were _____, (Ex: Driver's license, passport, etc.) to be the person who signed the preceding document in my presence and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature _____

State of _____

County of _____

Commission Expires: _____

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Bureau of Health Professions Licensure 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 the Bureau of Health Professions Licensure with written notice of my intent to withdraw consent to a CORI check.

I also understand that the Bureau of Health Professions Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me.

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

_____ _____

Signature of CORI Subject *Date*

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____

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

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

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION (Complete only if signed by BHPL staff)

*The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____

Print Name of Verifying BHPL Employee

_____ _____

Signature of Verifying BHPL Employee *Date*

Authentication of Signature
Please note that ALL fields in this section must be completed by the Notary Public. Evidence of identification must be government issued photo ID.

On this ____ day of _____ , 20___, before me, the undersigned notary public, _____ (name of applicant) personally appeared, proved to me through satisfactory evidence of identification, which were _____, (Ex: Driver's license, passport, etc.) to be the person who signed the preceding document in my presence and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature _____

State of _____

County of _____

Commission Expires: _____