

## SUPERINTENDENT'S VERIFICATION FOR INITIAL HEALTH ASSISTANT LICENSURE

**Applicant's Name** \_\_\_\_\_

**Social Security Number** \_\_\_\_\_

**Address** \_\_\_\_\_

Street Address or Post Office Box

\_\_\_\_\_

City, State, Zip Code

I, \_\_\_\_\_, hereby certify that I have verified that the  
*Printed Name of Superintendent or his/her Designee*  
above applicant:

- License needs to be issued for current School Year (SY)
- License needs to be issued for next School Year (SY)

\_\_\_\_\_ has earned a high school or high school equivalency diploma

\_\_\_\_\_ is at least eighteen (18) years of age,

\_\_\_\_\_ holds a current Certification in CPR;

\_\_\_\_\_ holds a current Certification in first aid;

\_\_\_\_\_ completed a NM Department of Health and Public Education Department training for school health assistants, related to state/federal laws, regulations and guidelines;

\_\_\_\_\_ verification by the school superintendent that a local orientation related to assigned duties, and facilitated by the PED licensed registered nurse, was satisfactorily completed.

\_\_\_\_\_ **Date:** \_\_\_\_\_  
(Signature of Superintendent or his/her Designee)

**District / Private School / Charter School:** \_\_\_\_\_