

D&S DIVERSIFIED TECHNOLOGIES

PO Box #418, FINDLAY, OH 45839-0418
TOLL FREE 877-8512355 — FAX 419-422-8328 — www.hdmaster.com

ARIZONA CERTIFIED NURSING ASSISTANT (CNA) EXAMINATION APPLICATION (forms 1101 & 1402) INSTRUCTIONS: (Also see www.hdmaster.com)

1. **DO NOT** mail this D&S Diversified Technologies CNA Examination Application to the Arizona State Board of Nursing (AZBN)
2. **Complete** front and back sides of this CNA Examination Application.
3. **Send** this completed application **with payment** to D&S Diversified Technologies, P.O. Box 418 Findlay, OH 45839-0418
4. You **must include** proof of completion of an Arizona State Board of Nursing (AZBN) 120 hour approved NA training program **and** proof of employment as a NA **if** your NA training is more than 24 months old.

NOTE: Facilities MAKE ALL CHECKS PAYABLE TO D&S DIVERSIFIED TECHNOLOGIES.

*******Candidate Personal checks are NOT accepted*******

Before submitting this testing application, please check off the following: (Incomplete applications will be returned to applicant for completion).

- This application is filled out **completely** (front and back) and **signed** where required.
- Exam payment** is included with the testing application.
- I have attached proof of my NA training to this application and proof of 160 hours of employment as a NA if my training is older than 24 months but, I understand that I can only test once and if I fail I must retrain and retest on both portions of my test. Your verification letter from your employer must be on company letterhead including 160 hours and dates of employment. (1/26/2009)**
- I have also completed the Arizona State Board of Nursing Application and sent that application to the AZBN.**

Candidate Information: (form 1101) Print clearly (Use Ink) or Type (high volume users on-line registration is available at www.hdmaster.com)

Social Security No. _____ - _____ - _____ (Mandatory. Your SS number will only be shared with the Arizona State Board of Nursing)

Applicant's Name _____
Last First MI Maiden/Former Name

Mailing Address (Street) _____ Apartment# _____ or PO Box # _____

City _____ State _____ County _____ Zip _____

Home Telephone _____ Message/Work Phone _____

Birth Date (Month/Day/Year) _____ / _____ / _____ E-Mail Address: _____
(Mandatory) Providing your email address is your authorization for us to use it for confirmation and results letters

I have successfully completed an AZBN approved 120 hour Nursing Assistant Training Program within the past 24 months or I have completed an AZBN approved training program more than 2 years ago and I have attached proof of employment to show that I have performed nursing assistant duties during every 24 month period since completing the training program.

Program Code # _____ Program Name _____
(On Certificate)

City _____ Date Completed _____ Contact Person _____

If facility is paying for your test, this section must be completed by Nursing Supervisor.

Facility Name _____ Phone _____

Address _____ Contact Person _____

Signature of Nursing Supervisor _____ Date _____

The written test is also available in Spanish. If you desire your written test to be in Spanish place an X in this box.

The written test is also available orally. If you desire your written test to also include an audio reading place an X in this box.

*******Checking both boxes will mean you are requesting an oral written test in Spanish.*******

I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. I hereby authorize release of my test results to my training program. I will honor my test appointment and agree to forfeit all test fees as payment for services provided if I do not show up for my test appointment. I will be responsible for any cancellation or rescheduling fees incurred as described in the Arizona candidate handbook. I also authorize a fax fee of \$5.00 charged to my credit card if I faxed my application into D&S. I also understand that if this is my first time testing that I must take both the written and skill test. If this is a re-take test I must re-test on the portion that I failed. I understand that if I paid by credit card that my credit card will be billed for both the written and skill test or for the portion of the test that I failed plus the fax fee. **PLEASE CALL THE FINDLAY OFFICE IF YOU DO NOT RECEIVE AN EMAIL OR REGULAR MAIL RESPONSE WITHIN FIVE DAYS. *****NO PERSONAL CHECKS ACCEPTED.*******

Candidate Signature _____

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Candidate **MUST** sign to verify acceptance (*unsigned applications will be returned*)

TESTING OPTIONS: Only use Option 1 or Option 2, never both.

Testing Option 1: Regional Test Sites – Application must be received at least ten days before first requested test date.

1st Choice Test Date: (From published 1700 AZ Test Schedule) **2nd Choice Test Date:** (From published 1700 AZ Test Schedule)

4 Digit Test Site #	Test Site Name	4 Digit Test Site #	Test Site Name
Test Month	Test Date	Test Month	Test Date

Testing Option 2: In-Facility Test Sites

(A CNA instructor must complete this section. The training program must be an AZBN/D&SDT certified test site to use this option.)
(High volume users may use Internet electronic application submission. Call 877-851-2355 for WEBETEST© application options and training.)

Name of Site _____ 4 Digit Test Site # _____

Contact Person _____ Phone _____

Contact Person E-Mail _____

Name of Test Observer _____

Date of Testing _____ Start time for Testing: _____ AM flight start _____ PM flight start

Site Address _____ City _____ State _____ Zip Code _____

List up to twelve candidate(s) Social Security numbers for In-Facility Testing:

Exam Types and Fee Payment: (form 1402)***NO PERSONAL CHECKS ACCEPTED*******

# Requested	Tests / Service Requested	Self-Pay Candidates	Skilled Nursing Facility Rate Only	Totals
	Written Test or Written Retake CIRCLE-- ENGLISH OR SPANISH	\$20.00	\$11.06ea	
	Oral Written Test or Retake CIRCLE -- ENGLISH OR SPANISH	\$30.00	\$16.59ea	
	Skill test or skill retake	\$65.00	\$35.95ea	
	Priority Fax Service	\$5.00	\$5.00ea	
	Overnight Shipping	\$19.50	\$19.50	
	Express Service Fee	\$15.00	\$15.00ea	
	No Show	No Refund	\$40.00	
	Reschedule	\$35.00	\$35.00	
	Cancellation	\$20.00	\$20.00	
			GRAND TOTAL:	\$

Check method of payment: Check (Facility Only) Cashier's Check Money Order Visa Master Card

Card #: _____ Expiration Date: _____ Authorized Signature: _____

Print name as it appears on your credit card: _____ Zip Code: _____

ADA ACCOMMODATION

I need special accommodation under the Americans with Disabilities Act. To qualify for special accommodations, you must provide written documentation of your disability along with your application. ADA form 1404 is available at www.hdmaster.com or call D&SDT 877-851-2355.

I also authorize a fax fee of \$5.00 charged to my credit card if I faxed my application into D&S. I also understand that if this is my first time testing that I must take both the written and skill test. If this is a re-take test I must re-test on the portion that I failed. I understand that if I paid by credit card that my credit card will be billed for both the written and skill test or for the portion of the test that I failed plus the fax fee. **PLEASE CALL THE FINDLAY OFFICE IF YOU DO NOT RECEIVE AN EMAIL OR REGULAR MAIL RESPONSE WITHIN FIVE DAYS. NO PERSONAL CHECKS ACCEPTED*******

Candidate Signature: _____ **(Unsigned applications will be returned)**