

# D&S DIVERSIFIED TECHNOLOGIES

PO Box #418, FINDLAY, OH 45839-0418  
TOLL FREE 877-201-0758 – FAX 419-422-8367 – www.hdmaster.com  
**PROVIDING CNA TESTING SOLUTIONS THROUGHOUT DELAWARE**

## D&S Diversified Technologies TESTING AND REGISTRY APPLICATION

**Every portion of this application must be completed. Incomplete applications will be returned unprocessed**  
**A completed Form 1402 DE MUST accompany this form. Please type or print.**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**D&S DT requests that you voluntarily supply your social security number on this application. Your social security number will be used as a primary identifier to locate your records in our database and will be provided only to Delaware State agencies. Your name will be placed on the Delaware CNA Registry after successful completion of a state approved competency evaluation test. NOTE: You may be eligible for reimbursement of training and testing fees that you have personally paid for. Please see the Delaware Candidate Handbook to see if you qualify.**

Name: \_\_\_\_\_  
Last First Middle Maiden/Former

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address: \_\_\_\_\_

Filling in your email address authorizes D&S DT to use email for your notification to test and test results.

**Please call the Findlay office if you do not receive an Email OR Regular mail response within 5 days.**

I hereby declare that the above supplied information is complete and accurate to the best of my knowledge and understand by signing this application **I will be scheduled for a test and responsible for all testing fees if I do not have an offer of employment. I will notify D&S DT immediately when any of the above supplied information changes.** 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.

Candidate Signature: (Candidate MUST sign:) \_\_\_\_\_ (Unsigned forms will be returned)

Please circle the correct information: Race: Asian Black Hispanic Native American Caucasian Other \_\_\_\_\_

Gender: Male Female **English is my Primary Language: Yes – No** If no list your primary language: \_\_\_\_\_

**Highest Education Level Completed: 7 – 8 – 9 – 10 – 11 – 12 – Post Secondary**

Please check the test(s) you are requesting:  WRITTEN TEST or  SKILL TEST or  BOTH Written and Skill Tests  ADA \_\_\_\_\_

**If you are requesting an ORAL version of the Written Test, please write ORAL in this box →**

The ORAL option includes a cassette tape on which questions are read out loud. There is an additional fee for an ORAL Test. (Please see Form 1402 DE.) The ORAL test only comes in English.

### Check off and complete ONLY ONE of the following SIX (6) choices.

I have successfully completed a Delaware Health & Social Services approved Training Program within the last two years.

1.  **Attach a copy of your Nursing Assistant training certificate. DO NOT complete the BACKSIDE of this form.**

Name of Training Program: \_\_\_\_\_ Training Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2.  I am currently enrolled in a **Nursing Program** and have satisfactorily completed a “Fundamentals/Basic Nursing” course with a clinical component. **These students will be approved to take the test upon submission of a letter from their school of nursing attesting to current enrollment status and satisfactory course completion as described.**

3.  I have completed a military nursing assistant training course or hospital-based nursing assistant training course of at least 150 hours with a curriculum comparable to the curriculum content of Section 69.303 of these regulations and who has performed nursing related services within the past 24 months. Complete the **Certificate of Military or Hospital Training Verification Affidavit on the backside of this form.**

4.  I am taking the examination because my CNA certification on the Delaware registry lapsed. **Attach a copy of your expired CNA registry certificate and complete the Lapsed Certificate Affidavit on the backside of this form.**

5.  I am certified as a CNA (GNA in Maryland) in a state other than Delaware but I do not have three months of full time employment. **Attach a copy of your current CNA certificate from the state where you are currently certified.**

6.  Individuals who have graduated from an RN or LPN program more than 24 months prior to application for certification are deemed qualified to meet the Department’s nurse aide training program requirements and are eligible to take the competency test upon submission of a sealed copy of their diploma.

Are you currently employed as a Nurse Aide? **Yes – No** If Yes -- employed since \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Circle) mm / dd / yyyy

At: \_\_\_\_\_  
Facility Name and Address Facility Location (City, State and Zip)

**Reschedule/Cancellation Policy:** Reschedules will be charged at the rate of \$27 for each reschedule and MUST be requested at least three business days prior to a scheduled test time. A cancellation request may be made to cancel a test any time up to 24 business hours prior to a scheduled test time (that is 48 hours for a Monday or holiday impacted test) and qualify for a full refund minus a \$27 cancellation fee that pays for costs incurred.

OFFICIAL USE ONLY: Site: \_\_\_\_\_ Packet#: \_\_\_\_\_ Test Date: \_\_\_\_\_ Scheduler: \_\_\_\_\_