HEADMASTER LLP
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Innovative, quality technology solutions throughout the United States since 1985.

NORTH DAKOTA
TEST OBSERVER APPLICATION
(FORM 1500ND)

This application must be accompanied by **FORM 1501ND** (Confidentiality / Non-Disclosure Agreement)

PERSONAL INFORMATION (PLEASE PRINT)

Social Security Number ________-________-___________ Email_________________________________ Date of Birth ______/______/______

Last Name ____First Name ________________________________ Middle________________

Address ____City ____________________________ State __________ Zip ____________

Home #: (_______) __________-_____________ Cell #: (_______) __________-____________ Work #: (_______) __________-____________

NURSE AFFIDAVIT

I am a registered nurse: Registry # _________________ with at least one year's experience in providing long term care for the elderly or the chronically ill of any age. (Nursing facility or swing bed setting acceptable.)

Supervisor _______________________________________ Facility ____

Phone Number (________) __________-__________ will verify my one-year work experience.

TESTING SITE INFORMATION

TEST OBSERVER:

I will be administering HEADMASTER Nurse Aide Written/Oral and/or Skills tests at the below listed HEADMASTER approved facility or lab based setting that meets State of North Dakota Department of Health requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER Nurse Aide Written/Oral and/or Skills tests as listed on form 1503ND. I will report as an irregularity any missing or substandard equipment.

I will administer tests with no compensation from HEADMASTER. I am administering tests for the facility listed below. Nurse Aide Candidates tested and/or any volunteer test subjects used will be covered by the facility liability policy. I hereby verify that I understand and agree with the statements contained herein and all supplied information is true and correct.

Facility____ City _________________________ State _________Zip ___________

Administrator____DON____

Phone number (_______) ________-___________ Fax number (______) _______-___________ Email___________________________________

APPLICANT AND FACILITY VERIFICATION

The signatures below certify and verify that the applicant is known to the approved testing facility and the information listed above for both facility and applicant is true and correct.

Administrator's Signature____ Date _________/_________/___________

Applicant's signature____ Date ________/_________/___________