D&S Diversified Technologies LLP
Headmaster LLP

D&SDT-HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604
(877)851-2355 – Fax: (406)442-3357
www.hdmaster.com | Email: hdmaster@hdmaster.com

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

D&S DIVERSIFIED TECHNOLOGIES (D&SDT)-HEADMASTER

OHIO STATE TESTED NURSE AIDE (STNA) EXAMINATION APPLICATION (FORM 1101OH)

A completed Form 1402OH with testing fees must accompany this form.

INSTRUCTIONS:

1. Complete both sides (if applicable) of this STNA Examination Application. *Completed paper applications must be received at D&SDT-HEADMASTER 10 business days prior to the testing day excluding Saturdays, Sundays & Holidays or express charges will occur.*
2. Send this completed application along with a completed Scheduling and Payment Form 1402OH and payment to P.O. Box 6609, Helena, MT 59604.

Check off and complete with only one of the following choices:

☐ I have successfully completed an Ohio Department of Health approved training and competency evaluation program within the last two years.
(Do not complete the backside of this form.)

Name of Training Program: _____ Training ODH#: _____

Address: _____ City: _____ State: _____ ZIP: _____

☐ I am enrolled in an Ohio Board of Nursing approved pre-licensure program of nursing education, or I am enrolled in a program of nursing education in another state.
Include a transcript from your school and have your instructor complete the Nursing Student Training verification on the backside of this form indicating your successful completion of courses that teach basic nursing skills including infection control, safety, emergency procedures and personal care.

☐ I have the equivalent of twelve months or more of full-time employment within the preceding five years as a hospital aide or orderly.
Please have an authorized representative of the hospital(s) where you worked complete the verification of hospital aide or orderly employment on the backside of this form verifying your work experience and attach on company letterhead your total overall hours worked and full or part-time status.

APPLICATIONS WITH INCOMPLETE PROGRAM INFORMATION OR MISSING REQUIRED DOCUMENTATION WILL NOT BE ACCEPTED AND WILL BE RETURNED.

Are you currently employed as a nurse aide? YES | NO *(circle one)* Employed since date: _____ | _____ | _____ *(month) (day) (year)*

Facility Name: _____ Facility Address: _____

CANDIDATE INFORMATION: *Print clearly (use ink) or type*

Are you a veteran, active duty or spouse of a veteran? YES | NO *(circle one)* Check which one applies: ____ Veteran ____ Active Duty ____ Spouse

Social Security No.: _____|_____|_____ *(Your social security number will be used to locate your record in our database and provided only to Ohio State Agencies.)*

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

Mailing Address: _____
(P.O. Box # ***-or-*** Street number and name, including Apartment # - if applicable)

City: _____ State: _____ Zip: _____

Cell Phone #: ( ) _____ Home Phone #: ( ) _____

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

The knowledge test is also available orally. If you desire your knowledge test to also include an audio reading place an X in this box. ☐
(With the ORAL version, only the first 59 questions will be read orally. The remaining twenty questions will have to be answered without oral assistance to assess English reading comprehension.)

ADA ACCOMMODATIONS: If you need special accommodations under the Americans with Disabilities Act, please see form 1404OH on the Ohio STNA webpage at www.hdmaster.com.

I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. If I do not have an offer of employment, I understand that by signing this application I will be scheduled for a test and responsible for all testing fees. 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 rescheduling, refund fees or dispute fees incurred as described in the Ohio STNA candidate handbook. Please call D&SDT at (877)851-2355 if you do not receive an email response within five days. Please refer to the Ohio STNA candidate handbook on the Ohio STNA webpage at www.hdmaster.com for testing policies and updates.

Candidate Signature_____ Date: _____ | _____ | _____

(UNSIGNED AND/OR INCOMPLETE APPLICATIONS WILL BE RETURNED)

-PAGE 1-

D&SDT-HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604
(877)851-2355 – Fax: (406)442-3357
www.hdmaster.com | Email: hdmaster@hdmaster.com

Verification of Nursing Student Training:

I verify that _____ is currently enrolled in a pre-licensure program of nursing education approved by the Ohio Board of Nursing, or by an agency of another state that regulates nursing education. I also verify that this individual has successfully completed the courses that teach basic nursing skills including infection control, safety, emergency procedures and personal care. If on a school break, this student is currently enrolled in the nursing program and scheduled to return to active class enrollment.

School of Nursing Name: _____

School Address: _____
(P.O. Box # ***-or-*** Street number and name)

City: _____ State: _____ Zip: _____

School Phone #: ( ) _____ Date: _____ | _____ | _____

Authorized Signature: _____ Printed Name: _____

Title: _____ Phone #: ( ) _____ Email: _____

******* A COPY OF THE STUDENT'S TRANSCRIPT MUST BE ATTACHED *******

Verification of Hospital Nurse Aide or Orderly Employment:

I verify that _____ has the equivalent of twelve months or more full-time employment in the preceding five years as a hospital nurse aide or orderly.

This individual was employed as a full-time nurse aide or orderly from _____ | _____ | _____ through _____ | _____ | _____

Hospital Name: _____

Hospital Address: _____
(P.O. Box # ***-or-*** Street number and name)

City: _____ State: _____ Zip: _____

School Phone #: ( ) _____ Date: _____ | _____ | _____

Authorized Signature: _____ Printed Name: _____

Title: _____ Phone #: ( ) _____ Email: _____

A WORK VERIFICATION LETTER ON COMPANY LETTERHEAD FROM EMPLOYER WITH DATES AND TIMES OUTLINING THE 1600 HOURS WORKED IN THE PRECEDING FIVE YEARS, ALONG WITH A JOB DESCRIPTION MUST BE ATTACHED