

D&S DIVERSIFIED TECHNOLOGIES

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PROVIDING STNA TESTING SOLUTIONS THROUGHOUT OHIO

D&S Diversified Technologies OHIO TESTING AND REGISTRY APPLICATION - Form 1101- UPDATED OCTOBER 2009

Every portion of this application must be completed and testing fees must accompany this form. Incomplete applications or no testing fees included will result in the return of this application and delay test scheduling

A completed Form 1402 OH 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 Ohio State agencies. Your name will be placed on the Ohio Department of Health STNA Registry after successful completion of a state approved competency evaluation test.

Name: _____
Last First Middle Maiden/Former

Home Address: _____ Apt # _____ 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 test confirmation notice and test results.

Please call the Findlay office if you don't get 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. Further,** 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 **AND** the express charges if received less than 10 days from my requested testing event.

Candidate Signature: _____

Candidate MUST sign (unsigned applications will be returned)

Gender: **Male Female** Please circle the correct information: (optional)

Please check the test(s) you are requesting: WRITTEN TEST or SKILL TEST or BOTH Written and Skill Tests and 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 all but the reading comprehension questions are read out loud.

You must read and answer nine questions without aide of the oral tape. There is an additional fee for an ORAL Test. Please see Form 1402 OH.

Check off and complete with ONLY ONE of the following three (3) choices.

1. I have successfully completed an Ohio Department of Health approved Training and Competency Evaluation Program within the last two years. **Attach a copy of your completed TCE certificate. DO NOT complete BACKSIDE of this form.**

Name of Training Program: _____ Training Completion Date: ____/____/____

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

2. 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 certificate of 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.

3. 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 or hospitals where you worked complete the Verification of Hospital Aide or Orderly Employment form on the backside of this form** verifying your work experience **and attach on company letter head total overall hours worked and full/part-time status**
Applications with Incomplete Program Information will be returned for completion.

Are you currently employed as a Nurse Aide? **Yes – No** Employed since ____/____/____
(Circle) mm / dd / yyyy

Facility Name and Address

Facility Location (City, State and Zip)

At: _____

Reschedule/Cancellation/No Show Policies:

Reschedule: An individual may reschedule **one time** during the three attempt testing cycle to a new mutually agreed upon test date and site for no charge **up to 24 hours from the actual testing time (excluding Sundays and holidays). Less than 24 hours from test time** and any further reschedules will be charged at the rate of \$35 for each reschedule which must be paid before the reschedule can occur.

Cancellations: A request may be made to cancel a test any time up to **24 hours from the actual testing time. Cancellations MUST be faxed or emailed, no phone calls will be accepted to qualify for a full refund minus a \$24 cancellation fee.** Cancellations or reschedules attempted **less than 24 hours from testing time** (excluding Sundays and holidays) will result in a NO SHOW status for the candidate.

No show status candidates will have to reapply by submitting new forms 1101 OH and 1402 OH and repay the entire testing fee. Please Note: If submitted forms are incomplete and/or the required documentation (TRAINING CERTIFICATE, NO SIGNATURE ON 1101 or PAYMENT is not included), this application will NOT BE ACCEPTED and will be returned for completion. Our official date of receipt will not be recorded until we receive the correct information and testing fees.

Official Use Only: Site# _____ Packet# _____ Test Date: _____ Scheduler: _____ 1402-06/2008