**OHIO TEST EVALUATOR APPLICATION form 1500**

Social Security #:______________________________

**Personal Information:** (Please type or print)

Name:________________________________________________________________________________________

(Last)                                           (First)                                        (Middle Initial)

Address:_______________________________________________________________________________________

(Street)                                                                                  (Apt. #)

_______________________________________________________________________________________

(City)                                                     (State)                            (Zip Code)

Date of Birth:                                                 ___

(Month)              (Day)           (Year)                                                       (Please circle one)

Sex: Male         Female

Phone:_________________________ Cell:________________ Fax:________________

(N)  __________________________________________ Home)                              (Work)

Nurse Affidavit:
I am a registered nurse in Ohio: Registry #__________________________ with at least one year’s experience in providing long term care for the elderly or the chronically ill of any age:

**Work Experience Verification:**

_________________________ of ____________________________________________ phone # __________________

Supervisor     Facility

will verify my one year's work experience.

**Testing Site:**
I will be administering D&S DIVERSIFIED TECHNOLOGIES Nurse Aide Written/Oral and/or Skill tests at an ODH approved facility or lab based setting that meets State of Ohio Department of Health and D&S Diversified Technologies requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the D&S DIVERSIFIED TECHNOLOGIES Nurse Aide Written/Oral and/or Skill tests as listed on form 1503 OH. I will not administer tests to my own students, family and friends, or to candidates trained within a corporate entity or organization that employees me. Also, I understand that if I use a person as an actor or WTP that they will not be eligible to sit for the STNA test for 6 months from the date they last helped during testing STNA candidates.

**Verification:**
I hereby verify that the above information is true and correct:__________________________/_____/____

(Applicant Signature)                   (Date)

**Reference:**
I certify that the applicant is known to me and the information listed above is true and correct.

____________________________________________________________________________________________________

(Reference Signature)     Address

Reference’s Title: ____________________________________________ Phone #:_________________________________

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D&S DIVERSIFIED TECHNOLOGIES use ONLY: EV ID # assigned: ___________________________ on ____________________

by____________________ Nursing Lic Verification: Date_______ Lic Expiration Date:______________ Other: _____