SOUTH DAKOTA TEST OBSERVER APPLICATION

South Dakota Health Care Association
804 N. Western Avenue --Sioux Falls, SD 57104
Phone# 605-339-2071
luannseverson@sdhca.org
Testing Services Provided by: HEADMASTER, LLP

All application materials MUST be sent to SDHCA-Attn: LuAnn Severson

IMPORTANT: Do not send pre-payment with this application, you will receive an invoice from Headmaster.

This form MUST be accompanied by Form 1501SD (Confidentiality/Non-Disclosure Agreement)

PERSONAL INFORMATION: (PLEASE PRINT)

Social Security Number __________-_______-_________Email____

Last Name ____ First Name_______________________Middle_________________

Address ____City ________________ State _____Zip ____________

Home Phone (605) ________-_________ Work Phone (605) ________-________ Date of Birth _______|_______|_______

NURSE AFFIDAVIT:

I am a Registered Nurse: Registry # ___________________ in good standing with the SD Board of Nursing and have at least one year's experience in providing long term care for the elderly or the chronically ill of any age as an RN.

Supervisor____Organization____

Phone Number (605) ___________-___________ will verify my one-year work experience.

TESTING SITE INFORMATION:

TEST OBSERVER: I will administer tests as a regular part of my duties with no compensation from HEADMASTER or SDHCA. I am working as a Test Observer for the organization listed below. Nurse Aide Candidates tested and/or any volunteer test subjects used will be employees and/or under contract of our organization and therefore covered by our organization's liability policy.

As a Test Observer for this organization, I understand that I have the option to test candidates who are not employed by our organization. I will administer these tests as a regular part of my duties with no compensation from HEADMASTER or SDHCA. Furthermore, candidates not employed and/or under contract by our organization that I agree to test will be covered by our organization's 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 __________

Supervisor_____________________________ Director of Nursing (if applicable)____

Phone# (605) ________-________ Fax# (605) _____-_______Email____

APPLICANT AND ORGANIZATION VERIFICATION:

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

Supervisor's Signature____ Date _______|_______|________

Applicant's Signature____ Date ______|_______|________