SOUTH DAKOTA SUBSTITUTE ID FORM
South Dakota Health Care Association
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Testing Services Provided by: HEADMASTER, LLP

Substitute ID Form

Section One

To be completed by Sponsoring Facility Representative prior to the Test Day. Please have candidate give this form to the Test Observer the day of testing. The Test Observer must send this form to HEADMASTER after testing of the candidate is completed.

Please Print:

I, _____, am authorized to complete this official substitute for State-issued photo identification to be presented to the Test Observer at the Test Site on the Test Day listed below. This substitution is in full compliance with HEADMASTER Certified Nurse Aide Test policies.

Candidate Name: _____ Social Security #: _____-_____-_____

Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____ Race: _____Age: _____ Sex: M / F

Test Site: _____ Four Digit Site #: _____ Test Date: _____/_____/_____

Candidate Signature: _____ Date: _____/_____/_____

I certify that the information above is complete and accurate, and that the Candidate has signed in my presence.

Sponsor Signature: _____ Title: _____ Date: _____/_____/_____

Section Two

To be completed by Test Observer on Test Day.

I am the Candidate named and described above, and am signing this document in the presence of the Test Administrator.

Candidate Signature: _____ Date: _____/_____/_____

Test Administrator Signature: _____ Date: _____/_____/_____