**WISCONSIN NURSE AIDE**

**WISCONSIN RN TEST OBSERVER INDEPENDENT CONTRACTOR APPLICATION - FORM 1500WI**

(Please type or print AND attach an updated resume AND a copy of your nursing license)

**Personal Information:**

Name: ____________________________

(Last) ____________________________ (First) ____________________________ (Middle Initial) ____________________________

Address: ____________________________

(Street) ____________________________ (Apt. #) ____________________________ (E-Mail) ____________________________

(City) ____________________________ (State) ____________________________ (Zip Code) ____________________________

Date of Birth: (Month) / (Day) / (Year)

Sex: Male Female

(Please circle one)

Phone: (Home) ____________________________ (Work) ____________________________ (Cell) ____________________________

**Nurse Affidavit:**

I am a registered nurse: License # ____________________________ with at least one year of long term care experience or providing care for the elderly or 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&SDT-HEADMASTER Nurse Aide Knowledge/Oral and/or Skill tests at a Wisconsin DHS (WDHS) approved facility and/or lab based setting that meets WISCONSIN DHS (WDHS) and D&SDT-HEADMASTER requirements. I will ensure that all necessary materials and equipment are available for the consistent administering of the D&SDT-HEADMASTER Nurse Aide Knowledge/Oral and/or Skill tests as listed on form 1503WI. I will not administer tests to students I have trained, a family member, or personal friend. Also, I understand that persons I use as actors or Knowledge Test Proctors (KTPs) will not be eligible to sit for the WI Nurse Aide test for 6 months from the date they last helped during a Nurse Aide test event.

**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 – City, State, ZIP) ____________________________ Phone #: ____________________________

To become an Independently Contracted Nursing Assistant Test Observer in Wisconsin, an RN must meet the guidelines set forth by D&SDT-HEADMASTER and WDHS. This includes successfully completing D&SDT-HEADMASTER specified training and meeting all other Test Observer certification requirements. Initial certification training is $100 and is non-refundable. Upon successful completion of his/her first test event, the RN will receive a $75 bonus for completing the final step of the certification process which is successfully managing his/her first complete test event. RN Observers must manage at least three test events per year to remain active. Test Observers must recertify yearly using a D&SDT-HEADMASTER approved recertification process.

**Check method of payment:**

☐ CHECK ☐ CASHIER’S CHECK ☐ MONEY ORDER ☐ VISA ☐ MASTER CARD

Card #: ____________________________ Expiration Date: ____________________________ Authorized Signature: ____________________________

Print name as it appears on your credit card: ____________________________ Zip Code: ____________________________

D&SDT-HEADMASTER use ONLY: Observer ID # assigned: ____________________________ on ____________________________ by ____________________________

Nursing License Verification: Date: ____________________________ License Expiration Date ____________________________ Other: ____________________________