WISCONSIN NURSE AIDE
RN TEST OBSERVER / KNOWLEDGE TEST PROCTOR / ACTOR
CONFIDENTIALITY / NONDISCLOSURE AGREEMENT - FORM 1501WI

This form must be completed and signed by new Actors and/or Knowledge Test Proctors who assist with testing.

I acknowledge the confidential nature of the nursing assistant competency examination. This includes the materials, processes, procedures and content of both the knowledge and manual skills portions of the examination. I agree to safeguard the confidentiality of all information about the nursing assistant competency examination. I will not disclose any portion of the examination materials and I will not disclose the processes or procedures necessary to administer or pass the examination nor will I disclose any examination results with instructors or administrators of any training facility or program.

If I am an RN Observer, I will not test or be involved in testing students I have trained, family members or close personal friends.

If I am a knowledge test proctor or an actor, I will not be involved in the testing of family members or close personal friends, except in emergency situations as provided for in the D&SDT-HEADMASTER and Wisconsin Guidelines. Also, I UNDERSTAND THAT AS AN ACTOR OR KNOWLEDGE TEST PROCTOR, I WILL NOT BE PERMITTED TO APPLY AND TAKE THE WISCONSIN NURSE AIDE TEST FOR 6 MONTHS FROM THE DATE THAT I LAST WORKED AS AN ACTOR OR KNOWLEDGE TEST PROCTOR.

This agreement extends to and includes, but is not limited to, allowing unauthorized persons to hear, view, videotape or otherwise gain any knowledge about the exam before, during or after the administration of an exam.

I recognize that disclosing or revealing, or allowing this information to be disclosed or revealed constitutes a violation of this agreement and could place my nursing license at risk and/or be subject to prosecution to the full extent of the law and/or a $100,000 fine. I agree to immediately report any known or suspected breach in security relative to the nurse aide competency examination by calling the D&SDT-Headmaster home office at (800) 393-8664.

____________________________________________________________     __________________________________
Actor Name (Print Clearly or Type)                                Social Security #
____________________________________________________________     ______________________________
Actor Address, City, State, Zip                                  Phone #
____________________________________________________________     __________________________________
Knowledge Test Proctor Name (Print Clearly or Type)              Social Security #
____________________________________________________________     _______(______)___________________
Knowledge Test Proctor Address, City, State, Zip                Phone #
____________________________________________________________     __________________________________
RN Test Observer Name (Print Clearly or Type)                    Email Address
____________________________________________________________     ______________________________
Observer Address, City, State, Zip                              Phone #
____________________________________________________________     ______________________________
____________________________________________________________     __________________________________
RN Test Observer Signature                                  Actor Signature
____________________________________________________________     __________________________________
Knowledage Test Proctor Signature
____________________________________________________________     ______________________________
____________________________________________________________     ______________________________
Date: ___/___/______