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WISCONSIN NURSE AIDE
ACTOR / KNOWLEDGE TEST PROCTOR TRAINING AFFIDAVIT – FORM 1511WI

I hereby swear that I, as a certified RN Test Observer testing Nurse Aide candidates in the State of WISCONSIN, have reviewed the approved D&SDT-HEADMASTER Actor training material with the Actor named herein and/or the approved Knowledge Test Proctor training material with the Knowledge Test Proctor named herein:

RN Test Observer Name (please print): _____ Date: _____/_____/_____

RN Test Observer Unique Email Address:_____

Address:_____ Phone(____)_____

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I hereby swear that I, as a Nurse Aide Skill Test Actor or Knowledge Test Proctor, have reviewed the Actor training material and/or the Knowledge Test Proctor training material with the RN Test Observer named above, and I understand and will abide by the D&SDT-HEADMASTER approved material presented:

Actor Name (please print): _____ Date: _____/_____/_____

Actor SS#: _____-_____-_____ Email:_____

Address:_____ Phone(____)_____ Date of Birth: ___/___/___

Knowledge Test Proctor Name (please print): _____ Date: _____/____/_____

Knowledge Test Proctor SS#: _____-_____-_____Email:_____

Address:_____ Phone(____)_____ Date of Birth: ___/___/___

(Fill in and sign both places if you are certifying as both an Actor **and** a Knowledge Test Proctor.)

I UNDERSTAND THAT AS AN ACTOR OR KNOWLEDGE TEST PROCTOR, I WILL NOT BE ABLE TO SIT FOR THE NURSE AIDE TEST FOR SIX (6) MONTHS FROM THE DATE THAT I LAST WORKED AS AN ACTOR OR KNOWLEDGE TEST PROCTOR.

_____

ACTOR SIGNATURE DATE

_____

KNOWLEDGE TEST PROCTOR SIGNATURE DATE

_____

RN TEST OBSERVER SIGNATURE DATE