D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
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ARIZONA MEDICATION ASSISTANT

TEST OBSERVER APPLICATION – FORM 1500AM

Personal Information: (Please type or print) **SOCIAL SECURITY NUMBER**: _____-_____-_____

Name: _____ _____ _____
(Last) (First) (Middle Initial)

Address: _____
(Mailing Address)

_____ _____ _____
(City) (State) (Zip Code)

Date of Birth: _____ _____ _____ **Sex:** Male Female
(Month) (Day) (Year) (Please circle one)

Phone: _____ _____ _____
(Home) (Work) (Cell)

Nurse Affidavit:
I am a registered nurse in ARIZONA: **Registry #** _____ with at least one year's experience in providing long term care for the elderly or the 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 HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES Medication Assistant Knowledge and/or Skill tests at an AZBN approved facility or lab based setting that meets State of ARIZONA BOARD OF NURSING and Headmaster/D&S Diversified Technologies requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES Medication Assistant Knowledge and/or Skill tests as listed on form 1503AM. I will not administer tests to my own students, family and friends, or to candidates trained within a corporate entity or organization that employees me. Also, I understand that if I use a person as an actor or knowledge test proctor (KTP) that they will not be eligible to sit for the Medication Assistant test for 6 months from the date they last helped during testing Medication Assistant candidates.

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)

Reference's Title: _____ Phone #:_____

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HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES use ONLY: ID # assigned: _____ on _____

by_____ **Nursing License Verification Date:**_____ **License Expiration Date**:_____