D&S Diversified Technologies LLP
Headmaster LLP

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Innovative, quality technology solutions throughout the United States since 1985.

Form 1101MP Updated 6-14-2011

MASSACHUSETTS MAP KNOWLEDGE TEST APPLICATION

(FORM 1101- KNOWLEDGE TEST)

MUST SEND FORM 1402 ALONG WITH THIS FORM.

INSTRUCTIONS: (Also see www.hdmaster.com) (Only a few un-sponsored candidates will ever use this paper application, if you are/were/have registered online yourself or your MAP Trainer or Employer registered you DO NOT also send this application to D&SDT. Provider sponsored candidates will not fill out this paper application.)

1. If you aren't/weren't/haven't registered online for the knowledge test then complete the front and back sides of this MAP Testing Application. Completed paper applications must **be received at the D&SDT office in Findlay, Ohio 10 business days prior to testing day. (Sundays & Holidays are not business days.)**
2. **If you didn't/weren't/haven't register(ed) online send** this completed application **with payment** to P.O. Box 418-Findlay, OH 45839-0418.

NOTE: Un-sponsored Training programs/employers - MAKE ANY COMPANY CHECK(s) PAYABLE TO D&SDT.

******CANDIDATE PERSONAL CHECKS ARE NOT ACCEPTED. CANDIDATES MUST USE MONEY ORDER, CASHIERS CHECK, CREDIT CARD******

Before submitting this testing application, please check off the following: (Incomplete applications will be returned to applicant for completion.)

- ☐ This application is filled out **completely** and **signed** where required.
- ☐ **Exam payment** is included with this paper testing application. (Form 1402.)
- ☐ I have listed **information from my MAP training issued certificate of graduation OPTION A or MAP Trainer verification OPTION B on** this application.

Candidate Information: (Form 1101) Print clearly (Use Ink) or Type (Most users will use on-line registration available at www.hdmaster.com)

Social Security No._____-_____-_____ (**Mandatory:** Your Social Security number will only be shared with the appropriate State Agencies.)

Applicant's Name_____
Last First MI Maiden/Former Name

Mailing Address (Street)_____Apartment# ____ or PO Box #_____

City_____ State_____ County_____ Zip_____

Home Telephone_____ Message/Work Phone_____

Birth Date (Month/Day/Year)____/____/____ E-Mail Address:_____
(Mandatory) Providing your email address is your authorization for us to use it for test confirmation and results letters.

Complete either OPTION A or B below.

A. I have successfully completed a State approved minimum 12 hour MAP Training Program within the past 12 months and I am providing my
Program Code #_____ Program Name_____(On Certificate) City_____

Date Completed_____ Contact Person_____Contact Person's phone #_____

B. I have successfully completed a State approved minimum 12 hour MAP Training Program within the past 12 months and I am providing my
Employer Name_____ Phone_____

Address_____Contact Person_____

Signature of authorized MAP trainer_____ Date_____

3. I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. I hereby authorize release of my test results to my MAP trainer or employer. I will honor my test appointment and agree to forfeit any testing fees paid as payment for services provided if I do not show up for my test appointment. I will be responsible for any cancellation, rescheduling, or dispute fees incurred as described in the Massachusetts MAP candidate handbook. I also authorize a fax fee of $5.00 charged to my credit card if I fax my paper application into D&SDT. I also understand that if this is my first time testing that I must pass the Knowledge test before I am eligible for the Medication Administration and Transcription tests. If this is a re-take test I must re-test on the portion of the MAP certification test that I failed. I understand that if I paid by credit card that my credit card will be billed for the portion(s) of the test that I am requesting plus the fax fee and any requested priority charges (if applicable). **PLEASE CALL 877-851-2355 IF YOU DO NOT RECEIVE AN EMAIL OR REGULAR MAIL RESPONSE WITHIN FIVE DAYS. *****NO CANDIDATE PERSONAL CHECKS are ACCEPTED.******* Complete PAPER applications must **be received 10 business days prior to my requested/anticipated testing day (excluding Sundays & Holidays) or I understand and agree that express charges will be applied per candidate. When you successfully pass the knowledge test your results letter will give you the information needed to schedule the Med Administration and Transcription tests.**

Candidate Signature_____
Candidate MUST sign verifying agreement with all listed requirements (*UNSIGNED APPLICATIONS WILL BE RETURNED*) ***Date***