RN OBSERVER - KNOWLEGE TEST PROCTOR
MAP CONFIDENTIALITY/NONDISCLOSURE AGREEMENT (Form 1501MP)

This agreement MUST be accompanied by ***Form 1505 MP or Form 1511 MP***

I acknowledge the confidential nature of the MAP tests. This includes the materials, processes, procedures and content of the knowledge, medication administration and transcription portions of the MAP test. I agree to safeguard the confidentiality of all information about the MAP test. I will not disclose any portion of the MAP test materials and I will not disclose the processes or procedures necessary to administer or pass the MAP test nor will I disclose any MAP test results to any MAP trainers or supervisors or any other third party.

If I am an RN observer, I will not test or be involved in testing my own students, family members, close personal friends or candidates trained within a corporate entity or organization that employs me.

If I am a knowledge test proctor, 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 guidelines. Also, I understand that as a knowledge test proctor, I will not be permitted to apply to take the Massachusetts MAP test for six months from the date that I was last used as a knowledge test proctor.

This agreement extends to and includes, but is not limited to, allowing unauthorized persons to hear, view, videotape, or otherwise to 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 report any known or suspected breach in security relative to the MAP test by calling the D&SDT home office at (800) 393-8664.

_____ _____
RN Observer Name (Print Clearly or Type) Social Security #

_____ _____(_____)_____
RN Observer Address, City and Zip Phone #

_____ _____
Knowledge Test Proctor Name (Print Clearly or Type) Social Security #

_____ _____(_____)_____
Knowledge Test Proctor Address, City, State, Zip Phone #

_____ ---------- _____
RN Test Observer Signature Knowledge Test Proctor Signature

Date:_____