

**D&S DIVERSIFIED TECHNOLOGIES LLP dba HEADMASTER LLP**  
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**MEDICATION AIDE TESTING AND REGISTRY APPLICATION**

**CANDIDATE INFORMATION (PLEASE TYPE or PRINT)**

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_  
Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date of Birth  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gender  Male  Female (optional information)

Race  Asian  Black  Hispanic  Native American  Caucasian  Other  
\_\_\_\_\_

**COMPLETE ONLY ONE OF THE FOLLOWING TWO CHOICES**

- I have successfully completed a Montana Board of Nursing approved Medication Aide Training Program.
- I hold an unencumbered Medication Aide License or certification in another state or US jurisdiction.

Are you currently employed as a Nurse Aide?  Yes  No Employed since  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Facility Name and Address \_\_\_\_\_

I hereby declare that the above supplied information is complete and accurate to the best of my knowledge and understand by signing this application I will be scheduled for a test and responsible for all testing fees incurred. I will notify HEADMASTER immediately when any of the above supplied information changes.

Candidate Signature \_\_\_\_\_ Date  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*If forms are incomplete and/or the required documentation and payment is not included, your application will not be accepted and will be returned for completion. An assigned test date will be officially recorded upon receipt of the correct information and testing fees.*