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WRITTEN TEST PROCTOR (WTP)
CONFIDENTIALITY/NONDISCLOSURE AGREEMENT

This agreement MUST be accompanied by **Form 1515 MT-CMA**

I acknowledge the confidential nature of the Montana Medication Aide competency examination, the materials for the written and manual skills portions of the examination and the processes, procedures and content of the written and/or manual skill portions of the examination. I agree to safeguard the confidentiality of all information about the Montana Medication Aide competency examination. I will not disclose any portion of the examination materials. I will not disclose the content of the examination and I will not disclose the processes or procedures necessary to administer or pass the examination. If I am an Evaluator I will not test or be involved in testing my own students, family members or close personal friends or candidates trained within a corporate entity or by organizations that employ me. If I am a written test proctor or an actor I will not be involved in the testing of family members or close personal friends, except in emergency situations as provided for in the Montana Medication Aide Guidelines. This agreement includes, but is not limited to, allowing unauthorized persons to hear, view, videotape, or allowing anyone to otherwise 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 Montana Medication Aide competency examination by calling the D&SDT home office at (800) 393-8664.

WTP _____ Social Security Number ____ - ____ - ____

Address _____ Home Phone (____) ____ - ____

WTP Signature _____ Date ____ - ____ - ____

HEADMASTER Signature _____ Date ____ - ____ - ____