D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
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NEVADA MEDICATION AIDE–CERTIFIED TEST OBSERVER APPLICATION – FORM 1500CV

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 NEVADA: **Registry #** _____ with at least one year of Nursing and Medication Administration experience as an RN.

Work Experience Verification:
_____ of _____ Phone # _____
(Supervisor) (Facility)
will verify my one year's work experience.

Testing Site:
I will be administering HEADMASTER - D&SDIVERSIFIED TECHNOLOGIES Medication Aide-Certified Knowledge and/or Skill tests at an NSBN approved facility or lab based setting that meets NEVADA STATE 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 Aide-Certified Knowledge and/or Skill tests as listed on form 1503CV. I will not administer tests to my own students, family and friends. Also, I understand that persons I use as an actors or KTPs will not be eligible to sit for the Medication Aide-Certified test for 6 months from the date they last helped during testing Medication Aide-Certified 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**:_____ Other:_____