

D&S DIVERSIFIED TECHNOLOGIES LLP (D&S DT)

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PROVIDING Medication Aide (MA) TESTING SOLUTIONS THROUGHOUT the United States

D&S Diversified Technologies

OHIO MEDICATION AIDE TESTING APPLICATION (Form 1101-OM)

Every portion of this application must be completed and testing fees must accompany this form. Incomplete applications or no testing fees included will result in the return of this application and delay test scheduling. A completed Form 1402 OM MUST accompany this form. Please type or print.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

D&S DT requests that you voluntarily supply your social security number on this application. Your social security number will be used as a primary identifier to locate your records in our database and will be provided only to Ohio State agencies.

Name: \_\_\_\_\_ Last First Middle Maiden/Former

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email Address: \_\_\_\_\_

Filling in your email address authorizes D&S DT to use email for your test confirmation notice and test results.

Please call the Findlay office if you don't get an Email OR regular Mail response within ten days.

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.

I will notify D&S DT immediately when any of the above supplied information changes.

Candidate Signature: \_\_\_\_\_

Candidate MUST sign

Gender: Male Female Please circle the correct information: (optional)

Please check the test(s) you are requesting: [ ] WRITTEN TEST or [ ] SKILL TEST or [ ] BOTH Written and Skill Tests

Check off and complete the following.

1. [ ] I am an STNA and have successfully completed an Ohio Board of Nursing approved Medication Aide Training Program within the last sixty days. Attach a copy of your completed MA training certificate. DO NOT complete BACKSIDE of this form. I also understand that if I fail any portion of my test that I must retest within 6 months of my failed test date, and that I may only test twice per training.

Name of Training Program: \_\_\_\_\_ Code: \_\_\_\_\_ Training Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2. [ ] I am a Residential Care Aide with one year experience and have successfully completed an Ohio Board of Nursing approved Medication Aide Training Program within the last sixty days. Attach a copy of your completed MA training certificate. DO NOT complete BACKSIDE of this form.

Name of Training Program: \_\_\_\_\_ Code: \_\_\_\_\_ Training Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Applications with Incomplete Program Information will be returned for completion.

Are you currently employed as a Nurse Aide? Yes - No Employed since \_\_\_\_/\_\_\_\_/\_\_\_\_ (Circle) mm / dd / yyyy

Facility Name and Address Facility Location (City, State and Zip)

At: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reschedule/Cancellation/No Show Policies:

Reschedule: An individual may reschedule one time, with 7 days prior notice, during the two attempt testing cycle to a new mutually agreed upon test date and site for no charge. Less than seven days notice or any further reschedule requests will be charged at the rate of \$35 for each reschedule which must be paid before the reschedule can occur.

Cancellations: A request may be made to cancel a test any time up to 3:00pm the business day before a scheduled test day and qualify for a full refund minus a \$23 cancellation fee. Cancellations or reschedules attempted after 3:00pm the business day before a scheduled test date will result in a NO SHOW status for the candidate. No show status candidates will have to reapply for a new testing day by submitting new forms 1101 OH and 1402 OH and repay the entire testing fee.

If forms are incomplete and/or the required documentation (TRAINING CERTIFICATE) or PAYMENT is not included, this application will NOT BE ACCEPTED and will be returned for completion. Our official date of receipt will not be recorded until we receive the correct information and testing fees.

OFFICIAL USE ONLY: Site: \_\_\_\_\_ Packet#: \_\_\_\_\_ Test Date: \_\_\_\_\_ Scheduler: \_\_\_\_\_