D&S Diversified Technologies LLP (D&S DT)

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Providing Medication Aide (MA) Testing solutions throughout the United States

OHIO MEDICATION AIDE TESTING APPLICATION (Form 1101-OM)

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.

Call the Findlay office if you do not get an e-mail OR regular mail response within ten days.

Please check the services you are requesting: ____ WRITTEN TEST ____ SKILL TEST ____ BOTH Written and Skill Tests
____ORAL ____ ADA ____ PAPER TEST

Check off and complete one of 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.

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. A LETTER FROM THE RESIDENTIAL CARE FACILITY ON COMPANY LETTER HEAD MUST ACCOMPANY THIS APPLICATION DOCUMENTING THAT THE INDIVIDUAL HAS WORKED IN A RESIDENTIAL CARE FACILITY FOR A MINIMUM OF 1600 HOURS.**

Name of Training Program: _____Code:_____ Training Completion Date: _____/_____/_____

Address: _____ City: _____ State: _____ ZIP: _____ .

Are you currently employed as a Nurse Aide? **Yes – No** (Circle) Employed since _____/_____/_____ mm / dd / yyyy

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

At: _____

Phone: _____Fax:_____

-Reschedules: An individual may reschedule **one time,** with 7 days notice prior to the test event, 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 OM and 1402 OM and repay the entire testing fee.

If forms are incomplete and/or the required documentation (form 1402, training certificate, signature, payment information) is not included, this application will NOT BE ACCEPTED and will be returned for completion. The official date of receipt will not be recorded until we receive the correct information and testing fees.

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 also declare that I agree with and understand the above policies. I will notify D&S DT immediately if any of the above supplied information changes. 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 cycle.

Candidate Signature: _____

(UNSIGNED APPLICATIONS WILL BE RETURNED)