D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
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Innovative, quality technology solutions throughout the United States since 1985.

OKLAHOMA
LONG TERM CARE [HOME HEALTH DEEMING] TEST OBSERVER APPLICATION FORM 1500KC

(PLEASE TYPE OR PRINT *AND* ATTACH AN UPDATED RESUME *AND* A COPY OF YOUR NURSING LICENSE *AND* INCLUDE THE CERTIFICATION FEE OF $99.95
(MADE PAYABLE TO HEADMASTER. ***PERSONAL CHECKS OR CASH WILL NOT BE ACCEPTED***)

Personal Information:

Social Security #_____

Name:_____ _____ _____
(Last) (First) (Middle Initial)

Address:_____ | _____
(Street) (Apt. #) (E-Mail)

_____
(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: **Registry #** _____ with at least one year experience in providing care for the elderly or chronically ill of any age.

Work Experience Verification:

_____ of _____ Phone # _____
(Supervisor to verify my year's work experience) (Facility)

Testing Site:

I will be administering HEADMASTER Long Term Care [Home Health Deeming] Knowledge and/or Skill tests at an Oklahoma approved facility or lab based setting that meets Oklahoma Department of Health and HEADMASTER requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER Long Term Care [Home Health Deeming] Knowledge and/or Skill tests as listed on form 1503KC. **I will not administer tests to my own students**, family members or personal friends. Also, I understand that any person I use as an actor or KTP will not be eligible to sit for the Long Term Care [Home Health Deeming] test for six months from the date they were last employed.

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 – City, State, ZIP)

Reference's Title: _____ Phone #:_____

****

HEADMASTER use ONLY: Observer ID # assigned: _____ on _____**by**_____

Nursing License Verification: Date_____**License Expiration Date**:_____Other:_____