HEADMASTER, LLP

3310 McHugh Lane, Helena, MT 59602
Toll Free 800-393-8664 – fax 406-442-3357 -- www.hdmaster.com
PROVIDING TESTING SOLUTIONS THROUGHOUT the UNITED STATES

HEADMASTER
TEST OBSERVER/WRITTEN TEST PROCTOR/ACTOR
CONFIDENTIALITY/NONDISCLOSURE AGREEMENT

This agreement MUST be accompanied by ***Form 1515GM and 1500GM***

I acknowledge the confidential nature of the medication aide competency examination. This includes the materials, processes, procedures and content of the written examination. I agree to safeguard the confidentiality of all information about the Oregon medication aide competency examination. I will not disclose any portion of the examination materials and I will not disclose the processes or procedures necessary to administer or pass the examination.

If I am an RN observer/WTP in Oregon, I will not administer tests to medication aide candidates with whom I have had a prior personal or business association or to my own students, family or close personal friends.

If I am a written test proctor or actor, but not an RN in Oregon, I will not be involved in the testing of medication aide candidates with whom I have had a prior personal or business association or to family or close personal friends. Also, I understand, as a written test proctor or actor, I will not be able to apply to take the Oregon medication aide examination for twelve months from the date that I last worked as a written test proctor or actor helping test medication aide candidates in Oregon. I understand I may only proctor medication aide written exams under the direct supervision of an Oregon RN.

This agreement extends to and includes, but is not limited to, allowing any unauthorized person to hear, view, videotape, or otherwise gain any knowledge about the exam or the exam processes and procedures before, during, or after the administration of any exam.

I recognize that disclosing or revealing or allowing any 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 incur a $100,000 breach of confidentially fine. I agree to report any known or suspected breach in security relative to the medication aide competency examination in Oregon by immediately calling the HEADMASTER home office at (800) 393-8664 or be considered as a party to the breach and treated as if I made the breach myself.

_____ _____
RN Observer Name (Print Clearly or Type) Social Security #

_____ _____(_____)_____
RN Observer Address, City and Zip Phone #

_____ _____
Actor Name (Print Clearly or Type) Social Security #

_____ _____(_____)_____
Actor Address, City, State, Zip Phone #

_____ _____
Written Test Proctor Name (Print Clearly or Type) Social Security #

_____ _____(_____)_____
Written Test Proctor Address, City, State, Zip Phone #

_____ _____ _____
RN Test Observer/WTP Signature Actor Signature Written Test Proctor Signature

Date:_____