



**ARIZONA NURSING ASSISTANT – HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES
ARIZONA TEST EVALUATOR / OBSERVER APPLICATION FORM 1500AZ**

(PLEASE TYPE OR PRINT AND ATTACH AN UPDATED RESUME AND A COPY OF YOUR NURSING LICENSE)

Personal Information:

Social Security # _____

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

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

_____ (City) _____ (State) _____ (Zip Code)

Date of Birth: ____ / ____ / ____ (Month) (Day) (Year) **Sex:** Male Female
(Please check 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) (Facility)

will verify my one year's work experience.

Testing Site:

I will be administering HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES (D&S DT) Nurse Aide Knowledge/Oral and/or Skill tests at a Arizona approved facility or lab based setting that meets Arizona BON and HEADMASTER/D&S DT requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER/D&S DT Nurse Aide Knowledge/Oral and/or Skill tests as listed on form 1503AZ. I will not administer tests to my own students, or a family member, personal friend, or to candidates trained within a corporate entity or organizational structure that employees me. Also, I understand that any person I use as an actor or KTP will not be eligible to sit for the NA 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/D&S DT use ONLY: Observer ID # assigned: _____ on _____ by _____

Nursing License Verification: Date _____ License Expiration Date: _____ Other: _____