D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
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MONTANA NURSING ASSISTANT – HEADMASTER

MONTANA TEST OBSERVER APPLICATION FORM 1500MT

(PLEASE TYPE OR PRINT *AND* ATTACH AN UPDATED RESUME, A COPY OF YOUR NURSING LICENSE AND APPLICATION FEE OF $89.95)

Personal Information: **Social Security #**_____-_____-_____

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

Address: _____
(Street) (Apt. #)

_____
(City) (State) (Zip Code)

Date of Birth:_____/_____/_____ **Sex:** ☐Male ☐Female _____
(Month) (Day) (Year) (Please check one) (E-mail)

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 since obtaining my RN license.
Work Experience Verification: Name of individual verifying work experience.

_____ _____ (_____)_____/_____
(Supervisor) (Facility Name) Phone #

Choose one or both testing options:

☐ **Regional Observer:** I will be administering HEADMASTER Nurse Aide Knowledge/Oral and/or Skills tests at HEADMASTER approved test sites that meet State of Montana Department of Health and Human Services (DPHHS) requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER Nurse Aide Knowledge/Oral and/or Skills tests as listed on form 1503MT. I will report as an irregularity any missing or substandard equipment to HEADMASTER staff. I also understand that to qualify as a Regional Test Observer I will need to maintain an Independent Contractor Exemption Certificate (ICEC) with the State of Montana.
☐ **In Facility Observer Only:** I will administer tests as a regular part of my duties with no compensation from HEADMASTER. I am working as a Proctor for the facility listed below. Nurse Aide Candidates tested and/or any volunteer test subjects used will be employees and/or residents of our facility and therefore covered by our facility liability policy. I hereby verify that I understand and agree with the statements contained herein and all supplied information is true and correct.

Facility_____ Administrator _____

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 #:(_____)_____-_____

Check method of payment: ☐ CHECK ☐ CASHIER'S CHECK/MONEY ORDER ☐ VISA ☐ MASTER CARD ☐ BILL FACILITY

Card #:_____ **Expiration Date:**_____ **Authorized Signature:**_____

Print name as it appears on your credit card:_____ **Zip Code:**_____

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

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