



**D&S Diversified Technologies LLP**

**Headmaster LLP**

**HEADMASTER LLP**

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

# NORTH DAKOTA TEST OBSERVER APPLICATION (FORM 1500ND)

This application must be accompanied by **FORM 1501ND** (Confidentiality / Non-Disclosure Agreement)

## PERSONAL INFORMATION (PLEASE PRINT)

Social Security Number _____ - _____ - _____		Email _____		Date of Birth ____/____/____	
Last Name _____		First Name _____		Middle _____	
Address _____		City _____		State _____ Zip _____	
Home #: (____) _____ - _____		Cell #: (____) _____ - _____		Work #: (____) _____ - _____	

## NURSE AFFIDAVIT

I am a registered nurse: Registry # _____ with at least one year's experience in providing long term care for the elderly or the chronically ill of any age. (Nursing facility or swing bed setting acceptable.)	
Supervisor _____	Facility _____
Phone Number (____) _____ - _____ will verify my one-year work experience.	

## TESTING SITE INFORMATION

### TEST OBSERVER:

I will be administering HEADMASTER Nurse Aide Written/Oral and/or Skills tests at the below listed HEADMASTER approved facility or lab based setting that meets State of North Dakota Department of Health requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER Nurse Aide Written/Oral and/or Skills tests as listed on form 1503ND. I will report as an irregularity any missing or substandard equipment.

I will administer tests with no compensation from HEADMASTER. I am administering tests for the facility listed below. Nurse Aide Candidates tested and/or any volunteer test subjects used will be covered by the 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 _____	City _____	State _____	Zip _____
Administrator _____	DON _____		
Phone number (____) _____ - _____	Fax number (____) _____ - _____	Email _____	

## APPLICANT AND FACILITY VERIFICATION

The signatures below certify and verify that the applicant is known to the approved testing facility and the information listed above for both facility and applicant is true and correct.	
Administrator's Signature _____	Date ____/____/____
Applicant's signature _____	Date ____/____/____