



OHIO MEDICATION AIDE - D&S DIVERSIFIED TECHNOLOGIES
SCHEDULING AND PAYMENT FORM (FORM 1402OM)

TESTING OPTIONS: Only use Option 1 or Option 2, *never both*

Testing Option 1: Fixed (Regional) Testing

This completed Form 1402OM must be received in our office 10 business days prior to the first requested test date (excluding Saturdays, Sundays and Holidays).

1st Choice Test Date (From Form 1700OM-Test Schedule)

Test Site #	Test Date	Test Site Name

2nd Choice Test Date (From Form 1700OM-Test Schedule)

Test Site #	Test Date	Test Site Name

Testing Option 2: Approved Flexible Test Sites Only *(In Facility training and Educational Programs testing in their own facilities.)*

Name of Site and Address:	4-Digit Test Site #	Agreed upon Test Date	Testing Time - AM	Testing Time - PM	Test Type <input type="checkbox"/> Electronic <input type="checkbox"/> Paper <i>Check which applies</i>	Testing Facility Contact Person's Name
Agreed Upon RN Test Observer Name:					Facility Contact Phone #	Facility Contact Email

List up to eight candidate(s) Social Security Numbers for testing:

Exam Types and Fee Payment

# Requested	Tests/ Service Requested	Price	Total
	Knowledge Test or Retake	\$30.00	
	Oral Knowledge Test or Retake	\$40.00	
	Skill Test or Retake	\$80.00	
	Reschedule	\$35.00	
	Refund Fee	\$35.00	
	Test Review Fee	\$25.00	
	Priority Fax Service	\$ 5.00	
	Overnight Shipping Fee	\$39.50	
	Express Service Fee	\$15.00 each	
	Total Charges Due		\$

Check method of payment: Check (Facility Only) | Cashier's Check | Money Order | Visa | Master Card

Made payable to D&SDT

Facility Pay: Purchase Order #:	Facility Name:	Facility Address:	Facility Phone:
Name of Authorizing Agent:	Title:	Phone:	Zip:
For Visa or Master Card Payment	Credit Card #:	Expiration Date:	Billing Zip Code:
Authorized Card Holder Name as it appears on your credit card:	Authorized Card Holder Signature:	Today's Date:	

ADA ACCOMMODATION: If you need special accommodations under the Americans with Disabilities Act please see form 1404OM available on the Ohio MA webpage at www.hdmaster.com.

NOTE: For Credit Card Payments- If payment is made by credit card and fee is disputed, you will be charged a \$35 charge back fee along with any testing fees.

I also authorize a fax fee of \$5.00 charged to my credit card if I fax my application to D&SDT-Headmaster [Fax #: (406)442-3357]. I also understand that if this is my first time testing that I must take both the knowledge and skill test. If this is a re-take test I must re-test on the portion that I failed. I understand that if I paid by credit card that my credit card will be billed for both the knowledge and skill test **or** for the portion of the test that I failed plus the fax fee. By signing this form I accept the policies as stated on this form and as stated in the Ohio MA candidate handbook. **Please call D&SDT at (877)851-2355 if you do not receive a test confirmation email within five days. **NO PERSONAL CHECKS ACCEPTED****

Candidate Social Security Number or Test Identification Number: _____ | _____ | _____ *(Your Test ID# is provided by your training program and in your test results email)*

Candidate Signature: _____ Date: _____ | _____ | _____

(UNSIGNED AND/OR INCOMPLETE APPLICATIONS WILL BE RETURNED)