OHIO STNA – D&S DIVERSIFIED TECHNOLOGIES (D&SDT) - HEADMASTER

OHIO RN TEST EVALUATOR / OBSERVER APPLICATION FORM 1500OH

(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: ________ | ________ | ________ **Sex:** Male Female
(Month) (Day) (Year) (Please circle one)

Phone: ( ) ______________ ( )______________ ( )______________
(Cell) (Home) (Work)

Nurse Affidavit:
I am a registered nurse in Ohio: **Registry #** ________________________ with at least one year experience in a long-term care facility providing care for the elderly or chronically ill of any age.

Work Experience Verification:
______________________________ of ______________________________ ( ) ______________
(Supervisor) (Facility) (Phone Number)
will verify my one year's work experience in a long-term care facility.

Testing Site:
I will be administering D&S DIVERSIFIED TECHNOLOGIES (D&S DT)-HEADMASTER Nurse Aide Knowledge/Oral and/or Skill tests at an Ohio Department of Health (ODH) approved facility or lab-based setting that meets ODH and D&SDT-HEADMASTER requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the D&SDT-HEADMASTER Nurse Aide Knowledge/Oral and/or Skill tests as listed on form 1503OH. 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 STNA test for six months from the date they were last used as an Actor or KTP.

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 #: ( )______________________

D&SDT-HEADMASTER use ONLY: **RN Test Observer** entered in TMU©: ______________ on ______________ **by** ______________
Nursing License Verification: Date: ______ | ______ | ______ **License Expiration Date**: ______ | ______ | ______ Other: __________