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Headmaster LLP

HEADMASTER LLP
P.O. Box 6609, Helena, MT 59604-6609
800-393-8664 – Fax: 406-442-3357
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HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES

ARIZONA MEDICATION ASSISTANT EXAMINATION APPLICATION (FORM 1101AM)

INSTRUCTIONS: (Also see www.hdmaster.com)

1. **DO NOT** mail this MA Examination Application to the Arizona State Board of Nursing (AZBN).
2. Complete this MA Examination Application. Completed paper applications must **be received at HEADMASTER 8 business days prior to the testing day excluding Saturdays, Sundays & Holidays or express charges will occur.**
3. **Send** this completed application **with payment** to **P.O. Box 6609-Helena, MT 59604-6609.**
   - You **must include** proof of completion of an Arizona State Board of Nursing (AZBN) 100 hour approved MA training program **OR** if you are a student nurse, approval must be obtained by submitting a waiver request to AZBN for approval (available from the Arizona Board or Nursing at www.azbn.gov). AZBN will notify HEADMASTER/D&S of approval **OR** if you are certified/registered as a Medication Assistant in another state, approval must be obtained by submitting a waiver request to AZBN for approval. AZBN will notify HEADMASTER/D&S of approval.

NOTE: Facilities MAKE ALL CHECKS PAYABLE TO HEADMASTER. ***CANDIDATE PERSONAL CHECKS ARE NOT ACCEPTED***

Before submitting this testing application, please check off the following: (Incomplete applications will be returned to applicant for completion.)

☐ This application is filled out **completely** and **signed** where required.

☐ **Exam payment** is included with the testing application.

☐ I have attached **proof of my 100 hours of MA training** to this application **OR** included a Nursing Student Waiver Request form ***approved*** by the AZBN **OR** if a Medication Assistant in another state, ***approval*** from AZBN must be received by Headmaster/D&S.

CANDIDATE INFORMATION: (Form 1101AM) Print clearly (Use Ink)

Social Security No.: _____ -_____ - _____ (**Mandatory:** Your Social Security number will only be shared with the Arizona State Board of Nursing)

Applicant's Name_____
Last First MI Maiden/Former Name

Mailing Address_____
(P.O. Box # ***-or-*** Street number and name, including Apartment # - if applicable)

City_____ State_____ Zip_____

Home Telephone_____ Message/Cell Phone_____

Birth Date (Month/Day/Year)_____/_____/_____ E-Mail:_____
(Mandatory) Providing your email address is your authorization for us to use it for test confirmation and results letters.

I have successfully completed an AZBN approved 100 hour Medication Assistant Training Program and understand that I must pass the test within one year from the completion of my training. If I am a certified/registered medication assistant in another state or a student nurse, and applying to test in Arizona, I understand I must complete a waiver request form and ***receive approval*** from the Arizona Board of Nursing (AZBN) prior to scheduling to take the Arizona Medication Assistant Exam.

Program Code #_____ Program Name_____(On Certificate) City_____

Date Completed_____ Contact Person_____

If facility is paying for your test, this section must be completed by Nursing Supervisor

Facility Name_____ Phone_____

Address_____Contact Person_____

Signature of Nursing Supervisor_____ Date_____

4. I hereby declare that the above supplied information is true, complete, and accurate to the best of my knowledge. I hereby authorize release of my test results to my training program. I will honor my test appointment and agree to forfeit all test fees as payment for services provided if I do not show up for my test appointment. I will be responsible for any cancellation, rescheduling, or dispute fees incurred as described in the Arizona candidate handbook. I also authorize a fax fee of $5.00 charged to my credit card if I faxed my application into HEADMASTER. 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 (if applicable). **PLEASE CALL 800-393-8664 IF YOU DO NOT RECEIVE AN E-MAIL OR REGULAR MAIL RESPONSE WITHIN FIVE DAYS. *****NO PERSONAL CHECKS ACCEPTED.*****
Complete paper applications must **be received 8 business days prior to the testing day (excluding Saturdays, Sundays & Holidays) or I understand and agree that express charges will be applied per candidate.**

Candidate Signature_____ _____
Candidate MUST sign to verify acceptance (*UNSIGNED APPLICATIONS WILL BE RETURNED*) **Date**