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NEVADA MEDICATION AIDE-CERTIFIED KNOWLEDGE TEST PROCTOR/ACTOR TRAINING AFFIDAVIT – FORM 1511CV

I hereby swear that I, as a certified RN Observer testing Medication Aide-Certified candidates in the State of NEVADA, have reviewed the Actor training material with the Actor named herein and/or the Knowledge Test Proctor (KTP) training material with the Knowledge Test Proctor named herein:

RN Observer Name (Please Print): _____ Date: _____/_____/_____

RN Observer SS#: _____-_____-_____ Email:_____

Address:_____ Phone(____)_____

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I hereby swear that I, as a Medication Aide-Certified Skill Test Actor or Knowledge Test Proctor, have reviewed the Actor training material and/or the Knowledge Test Proctor training material with the RN Observer named above, and I understand and will abide by the material presented:

Actor Name (Please Print): _____ Date: _____/_____/_____

Actor SS#: _____-_____-_____ Email:_____

Address:_____ Phone(____)_____

Knowledge Test Proctor Name (Please Print): _____ Date: _____/_____/_____

Knowledge Test Proctor SS#: _____-____-_____Email:_____

Address:_____ Phone(____)_____

(Fill in and sign both places if you are certifying as both an Actor **and** a Knowledge Test Proctor.)

I UNDERSTAND THAT AS AN ACTOR OR KNOWLEDGE TEST PROCTOR, THAT I WILL NOT BE ABLE TO SIT FOR THE MEDICATION AIDE-CERTIFIED TEST FOR SIX (6) MONTHS FROM THE DATE THAT I LAST WORKED AS AN ACTOR OR KNOWLEDGE TEST PROCTOR.

_____

ACTOR SIGNATURE DATE

_____

KNOWLEDGE TEST PROCTOR SIGNATURE DATE

_____

RN TEST OBSERVER SIGNATURE DATE