



**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).*

**1<sup>st</sup> 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	
	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 | \*\*NO PERSONAL CHECKS ACCEPTED\*\* | D&SDT-Headmaster does not accept cash*

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](http://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.

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)