HEADMASTER, LLP

3310 McHugh Lane, Helena, MT 59602
Toll Free 800-393-8664 – fax 406-442-3357 -- www.hdmaster.com
PROVIDING TESTING SOLUTIONS THROUGHOUT the UNITED STATES

Oregon Medication Aide **TEST OBSERVER APPLICATION** Form 1500GM

Personal Information: (Please type or print)

Social Security #_____-_____-_____

Phone:(____)_____
(Home) (Cell) (Work) (Fax)

Name:_____
(Last) (First) (Middle Initial)

Address:_____
(Street) (Apt. #)

_____
(City) (State) (Zip Code)

Date of Birth: _____ **Sex:** Male Female
(Month) (Day) (Year) (Please circle one)

Nurse Affidavit:

I am a registered nurse with an unencumbered OREGON nursing license: **Registry #** _____

Work Experience Verification:_____**Phone:**_____
(Supervisor)

Facility Name:_____**Address:**_____ will verify my RN work experience.

Work Expectations:

I will administer HEADMASTER medication aide written tests at HEADMASTER approved testing sites that meet Oregon State Board of Nursing and HEADMASTER requirements. In addition, I will insure that all necessary materials and equipment are available for the consistent administration of the HEADMASTER medication aide written/oral tests. I will not administer tests to medication aide candidates with whom I have a prior personal or business association or to my own students, family or close personal friends. I also understand that any person I use as an actor or WTP will not be eligible to take the test to become a medication aide in Oregon for twelve months from the last date they worked as an actor or written test proctor at a test event where medication aide tests were administered.

Verification:

I hereby verify that the above information is true and correct and I understand and will abide by all terms and conditions agreed to:

_____/_____/_____
(Applicant Signature) (Date)

Reference:

I certify that the applicant is known to me and the information listed above is true and correct to the best of my knowledge.

_____
(Reference Signature) Address

Reference's Title: _____ Phone #:_____

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HEADMASTER use ONLY: Observer ID # assigned: _____ on _____
by_____ **NURSING LICENSE VERIFICATION: DATE**_____ **EXPIRATION DATE** _____
HEADMASTER Official

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OSBN use ONLY: Approved by _____ on _____/_____/20_____