D&S Diversified Technologies LLP
Headmaster LLP

HEADMASTER LLP
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ARIZONA NURSING ASSISTANT – HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES

ARIZONA TEST EVALUATOR / OBSERVER APPLICATION FORM 1500AZ

(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: ( )_____ **( )**_____ **( )**_____
(Home) (Work) (Cell)

Nurse Affidavit:

I am a registered nurse: **Registry #** _____ with at least one year experience in providing care for the elderly or chronically ill of any age.

Work Experience Verification:

_____ of _____ Phone # _____
(Supervisor) (Facility)
will verify my one year's work experience.

Testing Site:

I will be administering HEADMASTER/D&S DIVERSIFIED TECHNOLOGIES (D&S DT) Nurse Aide Knowledge/Oral and/or Skill tests at a Arizona approved facility or lab based setting that meets Arizona BON and HEADMASTER/D&S DT requirements. In addition, I will be sure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER/D&S DT Nurse Aide Knowledge/Oral and/or Skill tests as listed on form 1503AZ. 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 NA test for six months from the date they were last employed.

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 #:_____

HEADMASTER/D&S DT use ONLY: Observer ID # assigned: _____ on _____ **by**_____

Nursing License Verification: Date_____ **License Expiration Date**:_____ Other:_____