

IDAHO NURSE AIDE TESTING AND REGISTRY APPLICATION

If you need any help with your application, please call the NATCEP School that you will be testing at.
Applications and form 1403 must be mailed to the NATCEP School
DO NOT send applications to Headmaster.

Every portion of this application must be completed. Incomplete applications will be returned unprocessed.

NURSE AIDE CANDIDATE INFORMATION

Social Security Number: _____ - _____ - _____

Name: _____
Last First Middle Maiden/Former

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Date of Birth: _____ Sex (circle) Male Female

Email Address: _____
Filling in you email address authorizes Headmaster to use email for notification of your test and test results.
(Please call 1-800-393-8664 if you do not receive an Email response within ten days.)

I hereby declare that the above supplied information is complete and accurate to the best of my knowledge. I will notify Headmaster immediately if any of the above information changes.

I hereby understand and give permission for my name to appear on the Idaho Nurse Aide Registry, when I pass both the Manual Skills Exam and Written or Oral Exam approved for the Idaho Nurse Aide Training and Competency Examination Program.

Candidate Signature

Date

Candidate MUST Sign & Date

PLEASE MARK (X) IN THE BOX NEXT TO THE TYPE OF EXAMINATION YOU ARE APPLYING TO TAKE

WRITTEN EXAM

ELECTRONIC EXAM (Results back same day where available)

ORAL EXAM (The ORAL option includes a Written Exam plus a cassette tape on which questions are read out loud. The Oral test comes in English Only. There is an additional fee for the Oral option)

OFFICIAL USE ONLY

PKT #

EMPLOYMENT INFORMATION

Please mark the box that applies to you

I am currently employed as a CNA in a Long-Term Care Facility (ie Nursing Home, Skilled Nursing Facility, Extended Care Unit of a Hospital)

I am currently employed as a CNA by a Hospice, Hospital, Home Health Agency, or as a Personal Care Provider.

NAME OF EMPLOYER _____

CITY OF EMPLOYER _____ EMPLOYMENT CODE: _____

I am currently NOT employed as a Nurse Aide.

IF YOUR CURRENT OR FORMER EMPLOYER PAID THE FEES FOR YOUR NURSE AIDE TRAINING AND/OR EXAMS, PLEASE PROVIDE THE FOLLOWING INFORMATION.

Date of Hire(MM/DD/YY)

Name of Employer/Facility

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE NURSE AIDE TRAINING PROGRAM REPRESENTATIVE

VERIFICATION OF COMPLETION OF AN APPROVED NURSE AIDE TRAINING PROGRAM

I verify that _____ successfully
(Print Name of Candidate)

completed a Nurse Aide Training program approved by the Idaho Department of Health and Welfare.

Name of Nurse Aide Training Program: _____

Instructor/Trainer Code: _____ Training Program Completion Date: ____/____/____

Signature of Person Verifying Information: _____

Phone Number of Person Verifying Information: _____

SKILLS EXAMINATION VERIFICATION

I verify that _____ has passed the Manual Skills
(Print Name of Candidate)

Examination upon successful completion of an approved Nurse Aide Training Program.

Name of Nurse Aide Training Program: _____

Date Skills Exam Passed: ____/____/____

Signature/Title of Person Verifying Information: _____