



**D&S Diversified Technologies LLP**  
**Headmaster LLP**

**HEADMASTER LLP**  
 P.O. Box 6609, Helena, MT 59604-6609  
 800-393-8664 – Fax: 406-442-3357  
 www.hdmaster.com

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## INSTRUCTOR AFFIDAVIT FORM – FORM 1302MT

This form verifies that the candidate listed below has completed a State of Montana Approved 75-hour or more Nurse Aide Training Course and must be signed by the training instructor to be valid.

Candidate Name: Last: \_\_\_\_\_ First: \_\_\_\_\_  
 (Please print)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (copied from the candidate's Social Security card)

I hereby certify that the above named Nurse Aide candidate has successfully completed \_\_\_\_\_ hours of formal Nurse Aide training that was taught using a State of Montana approved curriculum, by an Instructor that has been and is currently approved by the State of Montana Health Department to provide Nurse Aide Training as per regulations described in 483.151 & 483.152 of the Federal Register Vol. 56 No. 187

Training Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Training Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Class Hours: \_\_\_\_\_

Lab and Clinical Hours: \_\_\_\_\_

Name of Training Facility: \_\_\_\_\_ Facility ID #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Instructor's Name: \_\_\_\_\_ RN/LPN License Number: \_\_\_\_\_

Position/Title: \_\_\_\_\_

\_\_\_\_\_  
 Instructor's Signature \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date