

**HEADMASTER NURSE AIDE TEST ADMINISTRATOR APPLICATION**  
**PO BOX 6609, Helena, MT 59604 - (406) 442-8656**

**PERSONAL INFORMATION: (please print or type)**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Initial: \_\_\_\_\_

Street: \_\_\_\_\_ Apt# \_\_\_\_\_

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

Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Ph# (406) \_\_\_\_\_ - \_\_\_\_\_ Work Ph#: (406) \_\_\_\_\_ - \_\_\_\_\_ Circle Sex: M F

**Nurse Affidavit:**

I am a registered nurse (Registry # \_\_\_\_\_) with at least one year's experience in providing long-term care for the elderly or the chronically ill of any age.

**Testing Site:**

I will be administering the HEADMASTER Nurse Aide Written/Oral and/or Skill tests at the below listed HEADMASTER approved facility or at a lab based setting that meets all State of Montana Health Department regulations. In addition, I will ensure that all necessary materials and equipment are available for the consistent administering of the HEADMASTER Nurse Aide Written/Oral and/or Skill tests.

**Approved Testing Facility:**

Name: \_\_\_\_\_

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

**Applicant/Facility Verification:**

The signatures below certify and verify that the applicant is known to the approved testing facility and the information listed above for both facility and applicant is true and correct.

\_\_\_\_\_  
Administrator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

**Sponsor:**

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

\_\_\_\_\_  
W. Logterman, R.N., BSN, (Sponsor) \_\_\_\_\_ Date: \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_



Assigned Test Administrator ID#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date: \_\_\_\_\_ \ \_\_\_\_\_ \ \_\_\_\_\_

Assigned Facility ID#: \_\_\_\_\_