

HEADMASTER, LLP

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PROVIDING NA TESTING SOLUTIONS THROUGHOUT THE UNITED STATES

TEST OBSERVER APPLICATION form 1500 OR

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 #** _____ and I have at least two year's experience in providing long term care for the elderly or the chronically ill of any age:

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

Facility Name: _____ **Address:** _____ will verify my two year's work experience in a long term care facility.

Work Expectations:

I will administer HEADMASTER nursing assistant written/oral and/or skill tests at a 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 nursing assistant written/oral and/or skill tests as listed on form 1503OR. I will not administer tests to nursing assistant 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 nursing assistant in Oregon for twelve months from the last date they worked as an actor or written test proctor.

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 #: _____

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

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