D&S Diversified Technologies

PO Box #418, Findlay, OH 45839-0418

Toll Free 877-8512355 — fax 419-422-8328 - www.hdmaster.com

PROVIDING NA TESTING SOLUTIONS THROUGHOUT VERMONT

D&S Diversified Technologies LNA TESTING APPLICATION (form 1101)

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

A completed **Form 1402 VT MUST** accompany this form. **Please type or print.**

Social Security Number: _____-_____-_____

D&S DT requests that you voluntarily supply your social security number on this application. Your social security number will be used as a primary identifier to locate your records in our database and will be provided only to Vermont State agencies. Your name will be placed on the Vermont NA Registry after successful completion of the state approved competency evaluation test and you meet the VBON qualifications for licensure. Nurse Aide Candidates with an offer of employment may not be charged for testing or training.

Name: _____

Last First Middle Maiden/Former

Home Address: _____Apt. #_____P.O. Box #_____

City: _____ State: _____Zip: _____Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ Date of Birth: _____/_____/_____

mm / dd / yyyy

Email Address:_____

Filling in your email address **authorizes D&S DT** to use email for your notification to test and test results.

Please call the Findlay office if you don't get an EMAIL or WRITTEN response within five working days.

I hereby declare that the above supplied information is complete and accurate to the best of my knowledge and understand by signing this application I will be scheduled for a test and responsible for all testing fees if I do not have an offer of employment. I will notify D&S DT immediately when any of the above supplied information changes. I hereby authorize the release of my test results to my training program of record. I also authorize a fax fee of $5.00 charged to my credit card **if** I faxed my application into D&S. I also understand that if this is my first time testing that I must take both the written and skill test. If this is a re-take test I must re-test on the portion that I failed. I understand that if I paid by credit card that my credit card will be billed for both the written and skill test or for the portion of the test that I failed plus the fax fee.

Candidate Signature:._____

Candidate MUST sign verifying acceptance **Date**

Please check the test(s) you are requesting: ___WRITTEN TEST ___SKILL TEST or ___BOTH Written and Skill Tests _____ADA (for ADA request contact the VBON at 802-828-2396 before submitting this application)

If you are requesting an ORAL version of the Written Test, please write ORAL in this box ----------→ [ ]

The ORAL option includes a cassette tape on which 86% of the questions are read out loud and 14% will be used to evaluate your reading comprehension.

Check off and complete ONLY ONE of the following two (2) choices.

1. ☐ I have successfully completed a Vermont Board of Nursing approved Training Program within the last twenty-four months.

Program Code #_____Training Program Name:_____

City:_____ Date Completed:_____Contact Person:_____

2. ☐ I am curently enrolled in an RN or LPN program of nursing education or I have other VBON pre-appproval to take the Vermont Nurse Aide exam. **Contact the VBON with questions about this approval.**

Are you currently **employed as a Nurse Aide or do you have an offer of employment in a SKILLED long-term care facility that is Medicare and Medicaid approved___Yes ___No If you answered yes to this question please list the name, address, phone # and contact person below:** (If you have any questions about reimbursed facilities please call 802-241-2345 Vermont Dept. of Disabilities, Aging, and Independent Living).

Facility Name_____ **Phone**_____**Department**_____

Address_____ **Contact Person**_____

SIGNATURE OF NURSING SUPERVISOR (or Program Administrator) IF Medicare/Medicaid approved

(if not signed application will be returned to you for completion)

X_____**Date**_____**Phone:**_____

Reschedule/Cancellation/No Show Policy: **Reschedules will be charged at the rate of $35 for each reschedule** and must be requested prior to the business day preceding a scheduled test day. **A cancellation request must** be made prior to the business day preceding a scheduled test day and will **qualify for a full refund minus a $25 cancellation fee for Non-VT funded tests (advance pay candidates). Non-VT funded candidates that NO SHOW for their scheduled test will forfeit their test fee and MUST apply for a new test date and pay another test fee. Facilities that are reimbursed for training and testing costs from VT will be charged a Cancellation fee of $25.00 or a No Show fee of $40.00 for any candidates that do not test once testing services are requested from D&S DT. Candidates will be placed on a test and hold results status until fee is received for Reschedules, Cancellations and No Shows. These fees partially offset D&S DT costs incurred for services requested and resulting work that is performed**. These fees will not be reimbursed by the Vermont Department of Disabilities, Aging, and Independent Living. Please mail to the above address after completion to avoid additional priority fax charges of $5.00 per candidate.

OFFICIAL USE ONLY: Site:_____Packet#:_____ Test Date:_____ Scheduler: _____