D&S Diversified Technologies LLP
Headmaster LLP

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Innovative, quality technology solutions throughout the United States since 1985.

Form 1500MP Updated 06/17/2011

MAP RN TEST OBSERVER APPLICATION (Form 1500 MP)

Personal Information: (Please type or print)

Social Security #_____

Name:_____
(Last) (First) (Middle Initial)

Address:_____
(Street) (Apt. #)

_____
(City) (State) (Zip Code)

Date of Birth:_____ **Sex:** Male Female
(Month) (Day) (Year) (Please circle one)

Phone:(____)_____(___)_____(___)_____
(Home) (Work) (Cell)

Nurse Affidavit:
I am a registered nurse: **Registry #** _____

Work Experience Verification:
_____ of _____ phone # _____
Supervisor Facility
will verify my work experience.

Testing Site:
I agree to consistently administer MAP tests at mutually agreed upon test events that I schedule myself to conduct at Massachusetts approved test sites that meet DDS/DMH and D&S Diversified Technologies requirements. In addition, I will be sure that all necessary materials and equipment are available for consistent administration of D&SDT MAP tests. (Equipment is listed on form 1503.) I will not administer tests to my own students, or a family member, personal friend, or to candidates trained within a corporate entity or organizational structure that employees me. **I understand that I must be an RN with an active license in the state of Massachusetts and have one year experience working as an RN.**

Verification:
I hereby verify that the above information is true and correct:_____/____/____
Attach an updated resume AND copy of nursing license. (Applicant Signature) (Date)

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

_____
(Reference Signature) Address

Reference's Title: _____ Phone #:_____

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D&S DIVERSIFIED TECHNOLOGIES use ONLY: Observer ID # assigned: _____ on _____
by_____**Nursing Lic Verification: Date**_____**Lic Expiration Date**:_____Other:_____