



NURSE AIDE COMPETENCY EVALUATION APPLICATION

State Form 43731 (R4/09-00)

Indiana State Department of Health-Division of Long Term Care

Your Social Security Number is being requested by this State Agency in accordance with 42 CFR 483.156(c)(1)(ii). Disclosure is mandatory, and this application cannot be processed without it.

SECTION I - APPLICANT INFORMATION

Name of Applicant			Social Security Number		
Street Address					
City		State	County		Zip Code +4
Date of Birth (mm/dd/yr)		Date of Hire (mm/dd/yr)		QMA number	

SECTION II - COURSE INFORMATION (30 HOUR CLASSROOM EDUCATION)

Name of Facility/School			Telephone Number (area code)		
Street Address				Facility Number	
City		State	County		Zip Code+4
Date of Classroom Completion (mm/dd/yr)		Program Director (printed)			

I verify that the above named applicant has successfully completed at least 30 hours of classroom instruction utilizing the Indiana State Department of Health (ISDH) approved standards and resident care procedures and that a summary of all assessment tools and the RCP checklist are completed and available in this applicant's file.

Program Director's Signature			Date (mm/dd/yr)		
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SECTION III - COURSE INFORMATION (75 HOUR CLINICAL EXPERIENCE)

Name of Facility			Telephone Number (area code)		
Street Address				Facility Number	
City		State	County		Zip Code+4
Date of Clinical Completion (mm/dd/yr)		Supervisor (printed)			

I verify that the above named applicant has successfully completed at least 75 hours of clinical experience supervised by a licensed nurse utilizing Indiana State Department of Health (ISDH) approved resident care procedures and that a summary of the RCP checklist are completed and available in this applicant's file.

Clinical Supervisor's Signature			Date (mm/dd/yr)		
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I verify that the above information is correct

Applicant's Signature		Telephone Number (area code)		Date (mm/dd/yr)	
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SECTION IV - APPLICANT'S TEST STATUS

- | | |
|---|---|
| <input type="checkbox"/> Completed Indiana 105 hour Training | <input type="checkbox"/> Foreign Nurse (<i>country</i>) _____ |
| <input type="checkbox"/> Transferring From SLO | <input type="checkbox"/> Student Nurse (<i>school</i>) _____
(<i>currently enrolled nursing student</i>) |
| <input type="checkbox"/> Psychiatric Attendant | <input type="checkbox"/> Graduate Nurse
waiting to: take Boards _____ retake Boards _____ |
| <input type="checkbox"/> Out of State CNA Verification (<i>name of state</i>) _____ | |
| <input type="checkbox"/> Other _____ | |

SECTION V - TEST/MONITOR INFORMATION

TEST NO. 1

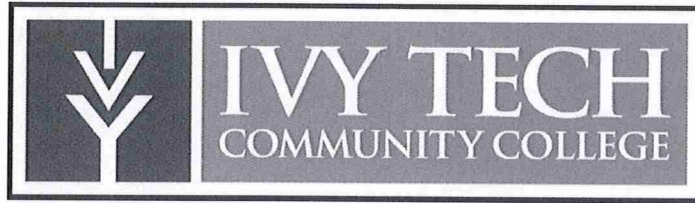
Test Entity		
Test Monitor		
Test Site		Test Date (<i>mm/dd/yr</i>)
Written Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Oral Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Skills Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail

TEST NO. 2

Test Entity		
Test Monitor		
Test Site		Test Date (<i>mm/dd/yr</i>)
Written Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Oral Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Skills Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail

TEST NO. 3

Test Entity		
Test Monitor		
Test Site		Test Date (<i>mm/dd/yr</i>)
Written Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Oral Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Skills Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail



CNA/QMA TESTING

www.ivytech.edu/cna

www.ivytech.edu/qma

Testing Request Form

Complete and submit this form with your Testing Application and Payment

Date: _____

First Name (please print): _____

Last Name (please print): _____

Address: _____

City, State, Zip: _____

Dates/Times to Avoid: _____

Preferred Testing Location (if any): _____

Preferred Form of Contact (choose one):

Phone

Email

Phone Number: _____

Email Address: _____

Use the space below to document any additional information: