SECTION 1: APPLICANT INFORMATION

Applicant's LEGAL Name: ___________________________ Last ____________ First ____________ M.J. ____________

Sex: __ F __ M

Address: ____________________________ Phone#: (____) ____________

City, State, Zip: ____________________________ County: ____________________________

Birth Date: ____________ CNA Registry #: ____________________________ SS#: ____________________________

*PRIVACY NOTICE TO APPLICANT: The Indiana State Department of Health is requesting disclosure of your Social Security Number to accomplish its purpose under IC4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

SECTION 2: COURSE INFORMATION (60 HOUR CLASSROOM EDUCATION)

Facility/School Name (no abbreviations): ____________________________ Phone#: (____) ____________

Address: ____________________________ ISDH QMA Training #: ____________________________

City, State, Zip: ____________________________ County: ____________________________

Date of Classroom Completion: ____________ RN Instructor's PRINTED Name: ____________________________

I verify that the above named applicant has successfully completed at least 60 hours of classroom instruction using ISDH approved training materials and that a summary of all assessment tools and checklists are completed and available in this applicant's file.

RN Instructor's Signature ____________________________ RN Instructor's License # ____________________________ Date ____________

SECTION 3: COURSE INFORMATION (40 HOUR PRACTICUM)

Facility Name: ____________________________ Phone#: (____) ____________

Address: ____________________________ ISDH QMA Training #: ____________________________

City, State, Zip: ____________________________ County: ____________________________

Date of Practicum Completion: ____________ Nurse Supervisor's PRINTED Name: ____________________________

I verify that the above named applicant has, under my supervision, successfully completed at least 40 hours of practical experience administering medications and performing procedures according to ISDH approved training materials.

Nurse Supervisor's Signature ____________________________ Nurse License # ____________________________ Date ____________

SECTION 4: APPLICANT VERIFICATION

I verify that all of the above information is correct. I understand that falsification of this document may result in denial or revocation of my qualification.

Applicant's Signature: ____________________________ Date: ____________
SECTION 5: CANDIDATE STATUS

- 100 HOUR CLASS
- Psychiatric Attendant
- Other: ___________________
- Out-of-State QMA - State: ___________________
- Nursing Student - School: ___________________
- Foreign Nurse - Country: ___________________

SECTION 6: DOCUMENTATION

The following required documents are included with this request to test:

- Original Application
- Original documentation of practicum
- Copy of High School Diploma, GED or transcript
- Copy of current Indiana Nurse Aide Registry certification letter

Nursing Students and Out-of-State QMAs must also include:

- Original ISDH approval letter & all documentation initially submitted to ISDH

Include testing fee of $60.00 (money order) payable to Professional Resources. Personal checks are not accepted.
Send all documentation and fee to: Professional Resources, PO Box 1552, Valparaiso, IN 46384-1552

SECTION 7: TEST RESULTS

**FIRST TESTING**

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**WRITTEN TEST RESULTS:** PASS______ FAIL______ SCORE:______

**SECOND TESTING**

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**WRITTEN TEST RESULTS:** PASS______ FAIL______ SCORE:______

**THIRD TESTING**

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**WRITTEN TEST RESULTS:** PASS______ FAIL______ SCORE:______
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: ________________________________

e-mail address: ________________________________

use the space below to document any additional information: