Wisconsin Nurse Aide Program NATIONAL NURSE AIDE ASSESSMENT PROGRAM (NNAAP®)

NATIONAL NURSE AIDE ASSESSMENT PROGRAM (NNAAP®) APPLICATION FOR THE COMPETENCY EXAMINATION

PLEASE PRINT LEGIBLY — USE INK ONLY

This application must be completed if you wish to apply to take the NNAAP® Examination. The personal information will only be used to determine whether you can be employed as a nurse aide, as well as to notify employers of your eligibility status. **Failure to provide complete and accurate information on the application may delay your nurse aide test or prevent your entry on the Registry.**

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ı	PERSONAL INFORMATION Social Security Number:												
١.	Providing your Social Security number is voluntary; however an identification number is needed to process your application. If you do not wish to												
	provide your Social Security number, you must attach a letter along with this application requesting that the Wisconsin Nurse Aide Registry provide												
	you with a nine-digit number to be used for Registry purposes.												
	Parts of Births												
	Date of Birth: MM DD YYYY Gender: Female Male												
	Current Legal Name: DO NOT USE NICKNAMES												
	LACT FIRST												
	LAST FIRST MI												
	Previous Legal Name: (If applicable)												
	LAST FIRST MI												
	CURRENT Mailing Address: CHECK HERE IF THIS IS A CHANGE OF ADDRESS.												
	STREET (number and name) APARTMENT NUMBER PO BOX												
	CITY STATE ZIP CODE												
	Home Phone Number: Work Phone Number: AREA CODE AREA CODE												
	E-Mail Address:												
2. 1	ELIGIBILITY ROUTES												
	E-I. NEW NURSE AIDE (not previously included on the Wisconsin Nurse Aide Registry), I have enclosed the following:												
	A copy of my certificate of completion from a nurse aide education program approved by the Wisconsin Department of Health Services; or												
	☐ I am applying to re-take the portion(s) of the NNAAP® Examination that I failed. A copy of my Score Report is attached.												
	E-4. OUT-OF-STATE TRAINED NURSE AIDE (I have previously applied for Reciprocity to Wisconsin but require testing).												
	A copy of my examination approval letter from the Wisconsin Department of Health Services is attached.												
	If you do not have the required documentation for the eligibility route listed above, please contact the Department of Health Services, Office of Carotives Quality at (608) 361, 831,9												
	of Caregiver Quality at (608) 261-8319.												
	E-5. LAPSED NURSE AIDE – nurse aide whose registration has lapsed because: My previous registration expired and I have not worked as a nurse aide in the past twenty-four (24) or more months.												
	E-7. HOME HEALTH NURSE AIDE.												
	You are included on the Wisconsin Nurse Aide Registry as an active nurse aide but do not hold the certification to be eligible to work in a												
	federally certified home health setting.												
	E-8. MILITARY – I have enclosed the following:												
	A copy of my examination approval letter from the Wisconsin Department of Health Services												
	If you do not have the required documentation for the eligibility route listed above, please contact the Department of Health Services, Office												
	of Caregiver Quality at (608) 261-8319.												
3. 5	SCREENING QUESTION												
	Do you have a SUBSTANTIATED FINDING OF CLIENT ABUSE, NEGLECT OR MISAPPROPRIATION OF CLIENT'S												
	PROPERTY listed on a nurse aide registry in any other state?												
	□ No □ Yes — Name of State □□□												

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4.	WISCONSIN NURSE AID	E TRAIN	VING P	ROGF	RAMI	NFO	RM	ATIO	N (t	o be c	ompl	eted	ONL	Y by	′ E- I	арр	licar	nts t	estin	ng fo	r the	first	time)
	Name of Program:		Ш								Щ			Щ		\perp	\perp		\bot	\perp			
	Program Number (FOR WISCONSIN APPROVED PROGRAMS ONLY:																						
	Enrollment Date: MM DD YYYYY Completion Date: MM DD YYYYY																						
	I hereby certify that the applicant has successfully completed a nurse aide training program offered by the training program named above and on the completion date indicated above.																						
	DATE SIGNATURE OF NURSE AIDE PRIMARY INSTRUCTOR																						
5.	TEST LOCATION:																						
At a Regional Test Site Provide the name and location of the test site in which you prefer to test. Please list all of your choices If none of your choices are available, you will be assigned the first available test site in your area. Go to Pearson VUE's web site a www.pearsonvue.com/wi/nurseaides to view a listing of Regional Test Sites.																							
	1st Choice Site:						Ĭ													\prod			
	2nd Choice Site:																		\prod	\prod			
	3rd Choice Site:																						
	☐ At an In-Facility Test	Site (Co	mplete	the in	forma	tion b	elo	w):														_	
	Site Name:																Ш		\perp	\perp	\perp		
6.	REGISTRATION FOR EXA	M & FE	ES																				
	FEES ARE NOT REFUNDABLE. If you have any questions about your application, please call Credentia at 877-437-9587 prior to sending in fees. Application fees submitted are valid for one year from the date received. Candidates who do not attend their exam will need to reapply to test and submit new fees. Under Federal Law, the Nurse Aide employed by a federally certified nursing home may be eligible for competency testing fee reimbursement. The registration fee must be paid in the form of a (I) CERTIFIED CHECK OR COMPANY CHECK, (2) money order, or (3) by credit card. NO PERSONAL CHECKS OR CASH WILL BE ACCEPTED. Payments must be made payable to Pearson VUE. Select the exam type and total amount due. If applicable, provide credit card information below.																						
	Credit Card Payment: MasterCard and Visa credit cards are accepted. The request for approval of credit card payments will be done only once. If card is declined, an alternate form of payment is required. Print and sign your name as it appears on your card. Indicate the credit card selection, credit card number, and expiration date. Mastercard Visa Credit Card # Expiration Date																						
	Name (Print): Signature:																						
	Exam Type							(hec	k/MO)	Cred	it Ca	ırd									
	I. Skills and Written Exams							4	11!	5		\$ 11	8.75		-								
	2. Skills and Oral Exams								11!	5		\$ 11	8.75										
	3. Skills ONLY (Attach your failing Skills score report.)											\$ 72	.25										
	4. Written ONLY (Attach your failing Written score report.)							\$	45			\$ 46	.50										
	5. Oral ONLY (Attach	your fail i	ing Oral	score re	eport.)			\$	45			\$ 46	.50										
																To)ta	ıl A	۱m	10	un	t D	ue:
																	\$].[

7. SIGNATURE OF APPLICANT

- I understand that I am responsible for making sure all of the information provided in this application is completely true and correct.
- I understand that any information I gave that is not true may jeopardize my eligibility status as a nurse aide.
- I understand if I have not received a letter from Credentia confirming receipt of my application within 10 days after it was submitted, I must call Credentia at 877-437-9587 to check the status of my application.

REQUIRED	REQUIRED	
Printed		
Name:	Signature:	
☐ CHECK HERE IF YOU DO NOT WISI UPON REQUEST.	I TO DISCLOSE YOUR NAME AND ADDRESS ON LISTS THAT ARE FURNISHED BY PE	EARSON VUE

You must submit Documentation of Eligibility (see Section 2), a PHOTOCOPY of a document that provides your name, date of birth, and Social Security number (for example, a current (not expired) driver's license or passport, and Social Security card, employee check stub or Internal Revenue Service form) along with this application, correct fee, and a photocopy of your identification together in one envelope.

Note: Make your certified check, company check, or money order payable to "Pearson VUE."

MAILTO: Pearson VUE Attn: Nurse Aide Processing 3 Bala Plaza West Suite 400A Bala Cynwyd, PA 19004

If paying by Credit Card, you may fax this application to (800) 838-2039.