



Arkansas Nursing Assistant Eligibility Screening Application

(Please print or type clearly and neatly.)

Instructions: Provide the information requested below. Incomplete or illegible forms will not be processed. Once your eligibility is approved, you will be scheduled for testing and will receive an Authorization to Test letter confirming your testing date, time and location.

Questions: For assistance in completing this application, please call Prometric at 800.818.8917.

Mail completed forms, along with all necessary documents (including the Examination Scheduling Form and training certification), and the appropriate fees to: Prometric, Attn: Arkansas Nursing Assistant Testing Program, 1260 Energy Lane, St. Paul, MN 55108.

Section 1. Candidate Information

Last Name	First Name	Middle Initial	Date of Birth (Month, Day, Year) / /
Street Address (including Apt. number or P.O. Box, if applicable)			
City	State	County (first four letters only)	ZIP Code
Home Phone Number (including area code) ()		E-mail Address (if available)	
Social Security Number or Alien ID Number - -		<input type="checkbox"/> Check this box if Alien ID Number is used.	
If you previously have tested or been certified in Arkansas, have you changed your name? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, provide your previous name and a copy of the legal documents that support your name change. Previous Name _____			
Are you a United States citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No. If no, you are required to provide a copy of the documents that prove your eligibility to work in the United States.			

Section 2. Certification Option/Eligibility

(See explanation of certification options in this bulletin beginning on Page 2. Once you choose an option, attach the required documents.)

<input checked="" type="checkbox"/>	Certification Route	Documentation that must be provided
	Option 1 - New Nursing Assistant: Completed AR-approved nursing assistant training within the last 12 months.	Copy of training completion document from a state-approved training program. Must include date of training completion.
	Option 2 - Previously certified as AR Nursing Assistant: Certification expired and nursing assistant did not meet renewal requirements.	Previous Certificate Number (if available):
	Option 3 - RN or LPN student.	Before completing this form, contact the OLTC at 501.682.1807. When approved by the OLTC, complete the application and attach a copy of the OLTC's approval letter.
	Option 4 - Home Health Aide trained.	Copy of certificate of training and completion of an HHA program approved under federal requirements. (This does not apply to Personal Care Aides.)
	Option 5 - This option is no longer available.	Not applicable.
	Option 6 - Completed a state-approved geriatric/long term care Nursing Assistant training program in a state other than Arkansas.	Before completing this form, contact the OLTC at 501.682.1807. When approved by the OLTC, complete the application and attach a copy of the OLTC's approval letter.
	Option 7 - Certified as a Nursing Assistant (Nurse Aide) in a state other than Arkansas.	Before completing this form, contact the OLTC at 501.682.1807 and ask for reciprocity/certification transfer forms.
	Option 8 - Other.	Before completing this form, contact the OLTC at 501.682.1807. When approved by the OLTC, complete the application and attach a copy of the OLTC's approval letter.

Section Three. Training Information

(This section must be completed if the applicant has selected Option 1, 4, or 6.)

Training Completion Date: __/__/__			
Name of Training Program			
Training Program Mailing Address (Street Address or P.O. Box)			
City	State	County (first four letters only)	ZIP Code
Training Program Phone Number (including area code) ()		Training Program Fax Number (including area code) ()	

Section Four. Employment Information

Current Employers: This section must be completed for any candidate who is currently employed in an AR nursing home. This application must be accompanied by the **original** letter documenting employment provided on facility letterhead indicating the candidate's employment dates, and signed by the facility administrator. **COPIES WILL NOT BE ACCEPTED.**

Potential Employers: Any candidate who has an offer of employment or intent to hire from an AR nursing home must complete this section. This application must be accompanied by the **original** letter of intent to hire the candidate upon successful completion of his/her competency evaluation provided on the nursing home's letterhead and signed by the facility administrator. **COPIES WILL NOT BE ACCEPTED.**

Name of Facility			
Facility Address (Street Address or P.O. Box)			
City	State	County (first four letters only)	ZIP Code
Employer Phone Number (including area code) ()		Name of Supervisor	

Section Five. Payment Information

All fees are due at the time of registration. **Two** certified checks or money orders are required. Checks and money orders must be made payable to Prometric. **Personal checks and cash are not accepted.**

<input checked="" type="checkbox"/>	Mark the Appropriate Box	Attach the Items Noted Below
	I have enclosed the nonrefundable \$10 eligibility screening fee and the \$79 testing fee; I do not have a letter of intent to be hired and I am not currently employed.	You must enclose two separate checks or money orders, one for \$10 and one for \$79 , both made payable to Prometric. If your eligibility is not approved, your testing fee will be returned to you.
	I have a promise of employment and have not included any fees.	You must attach a letter of intent to be hired from your potential employer on facility letterhead and signed by the administrator of the facility.
	I am currently employed and have not included any fees.	You must attach a letter from your employer on facility letterhead and signed by the administrator of the facility showing your employment dates.

Credit Card Payment: To pay by credit card, please complete the information below:

Card Type (Check One) <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa	Card Number	Expiration Date
Name of Cardholder (Print)	Signature of Cardholder	

Section Six. Applicant's Affidavit: MUST be completed by all Applicants

I certify that I am the applicant who is referred to in this application and that the statements herein are true. I understand that the results from my Competency Examination will be released to my nursing home employer or training program. I also understand that if it is found that I engaged in prohibited behavior during the test, my test will not be scored and I may be disqualified from any future testing. I have read and understand the information in the Arkansas Nursing Assistant Candidate Information Bulletin.

Applicant's Signature

Date