



# New Mexico Certified Nursing Assistant Examination Application

## Instructions

- Please go to **www.prometric.com/NurseAide/NM** to print the current version of this application and all other forms. **DO NOT submit photocopies** as this may impact the ability to process the application.
- Incomplete, blurred or illegible forms **will not** be processed.
- All submitted applications **must** include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Prometric, ATTN: NM Nurse Aide Program, 7941 Corporate Drive, Nottingham, MD 21236.**



The name you provide on this application **must** match **EXACTLY** the name on your government-issued identification you will provide on the day of testing. If the name does not match **EXACTLY**, you **will not** be permitted to take your exam and **will forfeit** any test fees.

If you have previously taken a nurse aide exam with Prometric and your legal name has changed since then, you **must** provide a **copy** of acceptable legal documentation along with this application. Acceptable documents include marriage certificate; divorce decree; birth certificate; and legal name change court documents. Prometric will be unable to process your application until the legal acceptable documents are received.

- **If applying for Testing Accommodations under the Americans with Disabilities Act (ADA):**
  - Please go to **www.prometric.com/nurseaide** to print the required ADA Accommodations Request Packet. This packet **MUST** be completed and submitted with this application.
  - Fill out the box below.

**Note:** Candidates applying to take the Oral (audio) Exam do not need to apply for ADA accommodations

I am applying for **Americans with Disabilities Act (ADA) accommodations**. I am requesting testing accommodations and have included the **required ADA Accommodations Request Packet** along with this application. I understand I must request accommodations **30 days in advance of the test date** and not **all** accommodations can be approved.

Yes       No

## Candidate Information

All fields marked with \* are required. Print one number/letter in each box where required.

*Have you taken a Certified Nurse Aide exam with Prometric? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*First Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Middle Initial <input type="text"/>
*Last Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
*Date of Birth (Month/Day/Year) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Previous name (if applicable):

*Street Address (including Apt. number or P.O. Box, if applicable)		
*City	*State	*ZIP Code
	□ □	□ □ □ □ □
*County (first four letters only)	* Phone Number (including area code)	
	□ □ □ - □ □ □ - □ □ □ □	
*Email Address (application will not be processed without an email address)		
Gender (optional) (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male		
Education Level - Check <b>only one</b> box next to your highest education level completed. <input type="checkbox"/> 4th grade or less <input type="checkbox"/> Some High School, did not graduate <input type="checkbox"/> One or two years of college <input type="checkbox"/> Between 5th and 8th grades <input type="checkbox"/> High School diploma or GED <input type="checkbox"/> Two-year college degree		

### Certification Option/Eligibility

Please check a certification route.

✓	<b>Certification Route</b>
	<b>Option 1</b> – New Nursing Assistant (New Mexico Trained).
	<b>Option 2</b> – Military Trained
	<b>Option 3</b> – Graduate RN or LPN
	<b>Option 4</b> – Out-of-State Nurse Aide (Expired)
	<b>Option 5</b> – Out-of-State or Foreign Trained Nurse/Nurse Aide (RN/LPN/NA)
	<b>Option 6</b> – RN/LPN Student
	<b>Option 7</b> – Expired New Mexico Certificate NM Certificate # _____
	<b>Option 8</b> – Expired New Mexico Certificate beyond 24 months but nurse aide has been working in nursing-related field NM Certificate # _____
	<b>Option 9</b> – Expired New Mexico Certificate/Retrained. NM Certificate # _____

### Training Information

This section must be completed if the **Certification Route 1, 4, or 6** was selected.

*Training Completion Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Training Program Code <b>T</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
*Name of Training Program		
*Training Program Mailing Address (Street Address or P.O. Box)		
City	State <input type="text"/> <input type="text"/>	ZIP Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Phone Number (including area code) ( <input type="text"/> )	Fax Number (including area code) ( <input type="text"/> )	
Program Director's or Instructor's Signature	Date	

### Work Verification

If you are currently employed or have been offered employment by a Medicaid certified nursing facility, this section must be filled out by an authorized facility representative in order to have the state pay your test fees. If this section is not completed, you must enclose a money order or cashier's check for the exam fees.

**Employer/Medicaid exam fees may be used for one attempt of an examination only each additional attempt will need to be self-pay. Lapsed candidates may not apply as State pay.**

Date of Hire: (MONTH/DAY/YEAR) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	Medicaid Provider Code (please provide complete code)
Name of Facility	
Facility Address	
City	State <input type="text"/> <input type="text"/> ZIP Code
<b>I verify that this nurse aide is employed or has been offered conditional employment in this qualified nursing facility.</b>	
Authorized Facility Representative's Signature	Date

### Test Site Information

Please check one of the following options.

✓	<b>Test Site</b>	
	<b>Testing at your Facility:</b> My training program or employer is scheduling my exam and I will take the exam at their facility. I will give this application form to the facility coordinator. <b>Do not send to Prometric.</b>	
	<b>Regional Test Site:</b> I am applying to test at a Regional Test Site. My preferred test site code is listed. <i>A current list of Test Sites with codes can be found online at <a href="http://www.prometric.com/NurseAide/NM">www.prometric.com/NurseAide/NM</a>.</i>	*Test site code:

### Exam Selection and Processing/Exam Fees

- **Acceptable Forms of Fee(s) Payment:** certified check, money order, MasterCard, Visa or American Express. Make certified checks payable to Prometric. **Personal checks** and **cash** are **not** accepted. Fees are **non-refundable and non-transferrable**.
- The **Payment Form** (last page) **must** be submitted with this application **regardless of payment type**.

\*Check payment type:     Self Pay                       State Pay

**A Reading Comprehension Exam will be automatically scheduled if you choose to take an oral version of the exam.**

<input checked="" type="checkbox"/>	First-Time Tester	Fee	5% NM State Tax	Total Fee	Total
	Clinical Skills and Written Test	\$102	\$5.10	\$107.10	\$
	Clinical Skills and Oral Test (English)	\$102	\$5.10	\$107.10	\$
	Clinical Skills and Oral Test (Spanish)	\$102	\$5.10	\$107.10	\$
<input checked="" type="checkbox"/>	Re-tester <sup>1</sup>	Fee	5% NM State Tax		Total
	Clinical Skills Retest	\$65	\$3.25	\$68.25	\$
	Written Retest	\$37	\$1.85	\$38.85	\$
	Oral Retest (English)	\$37	\$1.85	\$38.85	\$
	Oral Retest (Spanish)	\$37	\$1.85	\$38.85	\$
		<b>Total Fee</b>			<b>\$</b>

<sup>1</sup> Retest fees are the candidate's responsibility and must be included with this application.

An additional rescheduling/no show fee may be required to reschedule an exam appointment with less than five business days' notice, no-shows, late arrivals, or not allowed to test. Reschedule fees may apply to roster changes made by IFT testing locations.

### Applicant's Affidavit and Candidate Release Statement

- I understand I am responsible for making sure all information provided in this application is completely true and correct.
- I understand if any information given is not true, my registration status as a nursing assistant may be at risk.
- I understand if I pass both parts of the Nursing Assistant Competency Exam, I will be placed on the New Mexico Nursing Assistant Registry.
- I understand I may be asked to play the part of the resident for another candidate on exam day.
- I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, DOH, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.
- I understand all information required on the registration application may be made available for public disclosure (except for Social Security Number).

\*Candidate Signature (in box below)

Date: \_\_\_\_\_

If you **DO NOT** receive your emailed ATT letter from Prometric within **10-14 business days** of receipt at Prometric, please contact Prometric.

**Questions:** For additional information, please visit our website at **[www.prometric.com/nurseaide](http://www.prometric.com/nurseaide)**.

Please make a copy of all completed forms for your personal records.



# Payment Form

\*Candidate Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_



**Note:** You have the option of submitting your application and payment online using your credit card at [www.prometric.com/en-us/clients/nurseaide](http://www.prometric.com/en-us/clients/nurseaide).

Check payment type:     Self Pay                       State Pay

**Please Note: Employer/Medicaid exam fees may be used for one attempt of an examination only each additional attempt will need to be self-pay. Lapsed candidates may not apply as State pay.**

**Credit Card Type (Check One)**

MasterCard     Visa     American Express

Card Number	Expiration Date □ □ / □ □
Amount \$ _____ . _____	C/C Security Code □ □ □ □
Name of Cardholder (Print)	
Signature of Cardholder	

**Certified Check or Money Order Payments**

Certified Check                       3<sup>rd</sup> Party/Facility Check                       Money Order

Certified Check/Money Order/3 <sup>rd</sup> Party/Facility Check Number (one number or letter in each box):
□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □

Please mail completed forms, all supporting documentation and fees/letters of Intent to Hire to:

**Prometric  
ATTN: NM Nurse Aide Program  
7941 Corporate Drive  
Nottingham, MD 21236**