

Delaware Certified Nursing Assistant Examination Application

Instructions

- Please go to **www.prometric.com/exams/nurseaide-de** 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.
- To apply online please go to **www.prometric.com/exams/nurseaide-de**.
- All submitted applications **must** include the **Payment Form** at the end of the application.
- Please mail completed original forms to **Prometric, ATTN: DE Nurse Aide Program, 6211 Greenleigh Avenue Suite 400 Middle River, MD 21220**.



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	
*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"/> <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"/> <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): <input type="text"/>

*Street Address (including Apt. number or P.O. Box, if applicable)		
*City	*State □ □	*ZIP Code □ □ □ □ □
* Phone Number (including area code) □ □ □ - □ □ □ - □ □ □ □		
*Email Address (application will not be processed without an email address)		
Ethnic Group (optional)(check one box) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian American/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Mexican American <input type="checkbox"/> Other Hispanic or Latin American <input type="checkbox"/> White <input type="checkbox"/> Other		
Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male		

Certification Option/Eligibility

Please check a certification route.

✓	Certification Route	Document(s) to Provide
✓	1 - New Nurse Aide	Training Instructor Signature.
	2 - Nursing Student	An official letter from your school indicating successful completion of a Fundamentals/Basic Nursing course with a clinical component of no less than 75 hours of instruction in a long term care setting.
	3 - Lapsed Nurse Aide	Verification of past certification.
	4 - Out of State Certification	A copy of your current CNA or GNA certificate
	5 - RN or LPN	A copy of your diploma.

Training Information

*Training Completion Date: □ □ / □ □ / □ □ □ □	*Training Program Code (if available - see completion certificate)
*Name of Training Program	
*Training Program Mailing Address (Street Address or P.O. Box)	
City	State □ □ ZIP Code □ □ □ □ □
I certify that this applicant has successfully completed a state-approved nurse aide training program.	
Training Instructors Name:	Training Instructor Signature:

Regional Test Sites

Bear Processional Institute - **deregbear**

2500 Wrangle Hill Road, Suite

Bear, DE 19701

Del Tech – Terry Campus – **deregdov1**

100 Campus Drive – Bldg. 400

Dover, DE 19901

Delaware Technical Community College – **dereggeo4**

21179 College Drive TBD

Georgetown, DE 19947

Test Site Information

Please check one of the following options if you are applying using **Route 1**.

✓	Test Site	
	Testing at your Facility: 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. Do not send to Prometric.	
	Regional Test Site: 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 above or online at www.prometric.com/exams/nurseaide-de.</i>	
	*Preferred Test Site Code (For Regional Testing Only - Options Below)	
	Secondary Preferred Site Code:	
	Third Preferred 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**.

✓	First-Time Tester	Fee	Total
	Written Test and Clinical Skills Test	\$115	\$
	Oral Test and Clinical Skills Test	\$115	\$
✓	Re-tester	Fee	
	Clinical Skills Test ONLY	\$75	\$
	Written Test ONLY	\$40	\$
	Oral Test ONLY <i>(You may select this option even if you previously took the Written test.)</i>	\$40	\$

An additional rescheduling/no show fee of \$25 is 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 Delaware 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, DHSS, 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**.

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/nurseaide.

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 3rd Party/Facility Check Money Order

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

Please mail completed forms, all supporting documentation and fees to:

**Prometric
ATTN: DE Nurse Aide Program
6211 Greenleigh Avenue
Suite 400
Middle River, MD 21220**