

*Street Address (including Apt. number or P.O. Box, if applicable)		
*City	*State	*ZIP Code
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
* Phone Number (including area code)		
<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"/>		
*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.

<input checked="" type="checkbox"/>	Certification Route
	New Nursing Assistant. Candidate has completed training from an approved training program within the last 24 months.

Training Information

* 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 (if available – see completion certificate)
*Name of Training Program	
*Training Program Mailing Address (Street Address or P.O. Box)	Training Program Phone Number:
*Training Program Instructor Name	
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"/>

Test Site Information

Please check one of the following options.

✓	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 online at www.prometric.com/NurseAide/WY</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.**

✓	Newly Trained Tester	Fee	Total
	Written (English) and Clinical	\$115	\$
	Written (Spanish) and Clinical	\$115	\$
	Oral (English) and Clinical	\$115	\$
	Oral (Spanish) and Clinical	\$115	\$
✓	Re-tester	Fee	
	Written Test (English) ONLY	\$30	\$
	Written Test (Spanish) ONLY	\$30	\$
	Oral Test (English) ONLY	\$30	\$
	Oral Test (Spanish) ONLY	\$30	\$
	Clinical Test ONLY	\$85	\$
		Total Fee	

An additional rescheduling fee of \$25 is required to reschedule an exam appointment with less than five business days' notice. 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 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 Wyoming 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 I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, WSBN, 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.

***Candidate Signature (in box below)**

Questions: For additional information, please visit our website at www.prometric.com/nurseaide/wy. Please make a copy of all completed forms for your personal records.

Payment Form

*Candidate Name: _____

*Date of Birth: _____

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

Prometric
ATTN: WY Nursing Assistant Program
7941 Corporate Drive
Nottingham, MD 21236