Connecticut Certified Nursing Assistant Examination Application

Instructions

• Please go to www.prometric.com/NurseAide/CT 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/NurseAide/CT.
• All submitted applications must include the Payment Form at the end of the application.
• Please mail completed original forms to Prometric, ATTN: CT 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 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? | ☐ Yes ☐ No |
| *Social Security Number | |
| ☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐ |

| *First Name | Middle Initial |
| ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

| *Last Name | |
| ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ |

APP CNACT 1 Rev. 11012016
*Date of Birth (Month/Day/Year)  Previous name (if applicable):

*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)

Gender (check one)  ☐ Female  ☐ Male

**Certification Option/Eligibility**

Please check a certification route.

✓ Certification Route

Route 1 - New Nurse Aide

Route 2 - Nurse or Student Nurse

Route 3 - Out-of-State Nurse Aide

Route 4 - Lapsed Nurse Aide

Route 5 – Completed Nurse Aide Training and took state exam within the last 24 months

Route 7 – Reciprocity

**Training Information**

This section must be completed if the Certification Route 1 or 5 is selected.

*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:
Test Site Information
Please check one of the following Routes.

- **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. A current list of Test Sites with codes can be found online at [www.prometric.com/NurseAide/CT](http://www.prometric.com/NurseAide/CT).

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.

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<th>Route Type</th>
<th>Fee</th>
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<tr>
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<td>Written Test and Clinical Skills Test</td>
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<tr>
<td>Oral Test and Clinical Skills Test</td>
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<td><strong>Re-tester</strong></td>
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<td>Clinical Skills Test ONLY</td>
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<td>Oral Test ONLY (You may select this Route even if you previously took the Written test.)</td>
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<td><strong>Other</strong></td>
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<td>Route 5 – trained and took state exam in last 24 months</td>
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<td>Route 7 – Reciprocity</td>
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<tr>
<td>Rescheduling/No Show</td>
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An additional rescheduling/no show fee of $20 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 Connecticut 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, the CDPH, 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.

Credit Card Type (Check One)

☐ MasterCard  ☐ Visa  ☐ American Express

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Certified Check or Money Order Payments

☐ Certified Check  ☐ 3rd Party/Facility Check  ☐ Money Order

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

Please mail completed forms to:
Prometic
ATTN: CT Nurse Aide Program
7941 Corporate Drive
Nottingham, MD 21236