MEDICATION ADMINISTRATION PROGRAM TESTING APPLICATION FORM
See page two for directions. Your Employer and MAP Trainer will help you complete this form.

1. Candidate Information – Please PRINT legibly.

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Maiden Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name (Family)</td>
<td>First Name</td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Apt. No.</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Work Telephone Number</td>
<td>Home Telephone Number</td>
</tr>
</tbody>
</table>

Date of Birth (Mo/Day/Yr) Email Address

2. Provider Information
(To be completed by Employer)

<table>
<thead>
<tr>
<th>Provider/Agency Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>(F/EIN)</td>
<td></td>
</tr>
</tbody>
</table>

Check One:DDS DMH Un-sponsored*

3. Initial Training Program Information (for Certification only)
To be completed by Approved MAP Trainer

<table>
<thead>
<tr>
<th>Date Completed (Mo/Day/Yr)</th>
<th>Approved MAP Trainer Code:</th>
</tr>
</thead>
</table>

Trainer Signature

3a. MAP Pretest Completion Information (for Certification only)
To be completed by Approved MAP Trainer

<table>
<thead>
<tr>
<th>Date Completed (Mo/Day/Yr)</th>
<th>Approved MAP Trainer Code:</th>
</tr>
</thead>
</table>

Trainer Signature

3b. Secondary Training Program Information (for Certification only)
To be completed by Approved MAP Trainer

<table>
<thead>
<tr>
<th>Date Completed (Mo/Day/Yr)</th>
<th>Approved MAP Trainer Code:</th>
</tr>
</thead>
</table>

Trainer Signature

4a. Testing Information (Red Cross Scheduled Sites Only)

Register me for (check one): ☐ Certification ☐ Recertification ☐ Competency
Location (check one): ☐ Red Cross site ☐ Provider Site (see instruction on reverse) If you want on-site testing, please contact ARC

Please indicate your testing location preference(s) by checking off a Red Cross site(s). You will be scheduled for the first available slot at the location you check. Please indicate any dates you are not available within the next 30 days (Mon. - Sat. 8:45am - 5pm).

I can take the tests at any of the locations below:

☒ Brockton ☒ Greenfield ☒ Hyannis ☒ Lowell ☒ Peabody ☒ Springfield ☒ Worcester
☒ Cambridge ☒ Haverhill ☒ Leominster ☒ New Bedford ☒ Pittsfield ☒ Waltham ☒ Wrentham

I am NOT available on the following dates: ____________

4b. Provider Agency Recertification Only

In order to be updated on the MAP Registry, and have a new MAP Wallet Card issued, you must complete section 1 and 2 of this application and attach the signed MAP Recertification Competency Evaluation Form and submit them to the American Red Cross Testing Office.

FOR RED CROSS TESTING OFFICE USE ONLY

Date 
Payment 
Written 

P/F/A Date 
Skills 

P/F/A Form-Tran Form-Med Admin 
Administrator’s Signature Date 

Written 

P/F/A Date 
Skills 

P/F/A Form-Tran Form-Med Admin 
Administrator’s Signature Date 

Written 

P/F/A Date 
Skills 

P/F/A Form-Tran Form-Med Admin 
Administrator’s Signature Date 

Written 

P/F/A Date 
Skills 

P/F/A Form-Tran Form-Med Admin 
Administrator’s Signature Date 

Written 

P/F/A Date 
Skills 

P/F/A Form-Tran Form-Med Admin 
Administrator’s Signature Date 

Written
This form is your application to take the written and skills/skills only tests which will place you on the Red Cross Maintained MAP Central Registry. Your Employer and an Approved MAP Trainer are available to answer questions or assist you in completing this form. Print all entries clearly in ink, one letter or number to a box. Unreadable or incorrect information may result in scheduling delays. The numbers for each section listed below match the numbers on page one of this form.

SECTION 1. CANDIDATE INFORMATION
Social Security Number:
Print your Social Security Number. It is the primary means of identifying you in the MAP Central Registry. If you do not have a Social Security Number, please enter all zeros.

Name: Enter your name as you want it to appear on your MAP Wallet Card.
Last (Family): Print the letters of your last, or family name. If you use more than one last name, leave a space empty between the names.
First: Print the letters of your first name.
Maiden (if applicable): Print the letters of your maiden name after your Social Security Number.

Address: Enter your mailing address. This is the address to which your testing information will be sent.
Street: Print your street address.
Apt. No.: Print your apartment number, if applicable.
City: Print the name of the city or town
State: Print the U.S. Postal Code abbreviation for your state (Massachusetts=MA).
Zip Code: Print your 5-digit Zip Code.

Home Telephone Number:
Print your home telephone number, including area code.

Work Telephone Number:
Print your work telephone number, including area code.

Date of Birth:
Print the numbers of the month, day and year of your birth in the spaces provided. If the number is one digit, place a 0 first. Example: April 15, 1965 = 04-15-65.

Email Address:
Print your complete email address.
Example: jdoe@yourcompany.org

SECTION 2. PROVIDER INFORMATION: This section may be completed by your employer. Print the provider agency name, Federal Employer Identification number (FEIN) and city where your “DDS” or “DMH” corporate office address is located. If you are not currently working for a provider, check off the unsponsored box and leave the rest blank.
*Unsponsored Candidates:
If you do not work for a DDS/DMH Agency test fees are as follows:

Initial Fees
$72 Certification Test
$45 Recertification Test

Retake Fees
$27 Written Test
$45 Skills Test

Our office does not accept Personal Checks. Please submit payment in the form of a Money Order or Bank Check.

SECTION 3. INITIAL TRAINING PROGRAM
INFORMATION (This section to be completed by trainer who provided MAP training)
Date Completed Training Program:
Print the month, day and year the training program was completed.

MAP Approved Trainer code and signature.
Print the four digit MAP trainer code and provide a signature.

SECTION 3a. MAP PRETEST COMPLETION INFORMATION
This section is to be completed by trainer who provided testing after successful completion of pretest by candidate

SECTION 3b. SECONDARY TRAINING INFORMATION
(This section is to be completed by your trainer and is for Certification candidates who have failed the Red Cross test 3 times)
Date Completed Training Program:
Print the month, day and year the training program was completed.

MAP Approved Trainer code and signature.
Print the four digit MAP trainer code and provide a signature of trainer who provided secondary training.

SECTION 4a. TESTING INFORMATION (Red Cross Sites Only)
Register me for:
Completing “Type of Test” needed:
Check the “Certification box” if you have already completed the MAP training program.
Check the “Recertification box” if you are currently listed in good standing in the MAP registry and your Certification will expire within the next 90 days or if your Certification expired within the last year.
Check the “Competency box” if you are currently certified in another state or are a licensed nurse working in a non-nursing role in a setting subject to the MAP.

SECTION 4b. TESTING INFORMATION
This Section to be completed if Recertification is through your provider.

Location:
Check your site preference. If a Provider site is checked, please call 1-800-962-4337 for special arrangements. Testing days and times are Monday-Friday, 8:45 a.m. to 5 p.m. Please note any days/times you are NOT available for testing.

DO NOT ENTER ANY INFORMATION IN THE AREA MARKED “FOR RED CROSS TESTING OFFICE USE ONLY.”

Mail To: AMERICAN RED CROSS TESTING OFFICE
143 MAIN STREET
CAMBRIDGE, MA 02142-1530
1-800-962-4337 / 781-979-4010
781-979-4014 Fax
http://BostonRedCross.org/testing massbaytesting@usa.redcross.org