

American Red Cross State Testing Office

MASSACHUSETTS NURSE AIDE TESTING AND REGISTRATION APPLICATION FORM

Go online to www.redcross.org to register for your test then bring this completed form on your test day

1. Candidate Information											
Social Security Number								Initial if no Social Security Number			
Last Name				First Name				Middle Initial			
Address										Apt No	
City						State			Zip		
Best Daytime Phone Number						Alternate Phone Number					
Date of Birth (Mo/Day/Year)						Email Address					

Social Security Number: Print your Social Security Number. It is the primary means of identifying you in the Massachusetts Nurse Aide Registry. If you have no SSN, you may leave that space blank and place your initials in the next space attesting that you may take the test but will not be issued a certificate once you pass the exam until we receive a copy of your social security card.

Name: Enter your current legal name as it appears on your State/Federal issued photo identification. If you use more than one last or first name, leave a space empty between the names.

Address: Enter your mailing address. This is the address to which your test results will be sent.

2. Eligibility Documentation (please check only one)	
<input type="checkbox"/>	I am testing for the first time and have attached a copy of my certificate of completion from a MA DPH approved training program
<input type="checkbox"/>	I am testing for the first time and have attached my MA DPH approved Nurse Aide Training Waiver Application
<input type="checkbox"/>	I am testing to renew my MA Nurse Aide License because I have a gap of employment of greater than 24 months and have attached a copy of my expired license or printed documentation of expired license
<input type="checkbox"/>	I was previously scheduled to test, but no longer have my retake form or it has been longer than one year since my most recent test date. No attachment required.

2a. Test Administration (please check any that apply)	
<input type="checkbox"/>	I would like to have the knowledge test administered orally and have paid the additional \$10 fee
<input type="checkbox"/>	I have submitted my request in writing with documentation from my health care professional to the State Testing Office and have been approved to take my test with Special Accommodations

3. Signature and Date	
By signing this application, you agree and attest to the following:	
I am the person whose name and personal information appears on this application. To the best of my knowledge, the information contained herein is true and accurate. I understand that if any of the information contained herein is not true, is misrepresented or is intentionally incomplete or inaccurate any and all test scores shall be forfeit and any resulting registration as a Certified Nurse Aide shall automatically be rendered null and void.	
Further, I give the American Red Cross authority to forward and/or transmit this data to the Massachusetts Department of Public Health (DPH) for inclusion on the Nurse Aide Registry. I understand that should there be any change to the personal information included herein, I am required to report those changes to the American Red Cross State Testing Office within thirty days of the change.	
Signature	Date

Red Cross Testing Office Use Only											
Test Date:			Test Date:			Test Date:			Test Date:		
Knowledge	Form	P F A	Knowledge	Form	P F A	Knowledge	Form	P F A	Knowledge	Form	P F A
Clinical	Form	P F A	Clinical	Form	P F A	Clinical	Form	P F A	Clinical	Form	P F A
Test Administrator:			Test Administrator:			Test Administrator:			Test Administrator:		
Scored By:			Scored By:			Scored By:			Scored By:		