American Red Cross State Testing Office

NEW HAMPSHIRE NURSE ASSISTANT TESTING 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

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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**

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.
Email Address: Enter your email address if you would prefer your results sent electronically. If left blank, your results will be mailed.

2. Eligibility Documentation (please check only one)

	I am testing for the first time and have attached a copy of my certificate of completion from an approved training program
	I am testing to renew my NH LNA License and have been approved to test by the NH Board of Nursing.
	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)

	I would like to have the knowledge test administered orally and have paid the additional $10 fee
	I have submitted my Special Accommodations request to the NH Board of Nursing 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 test scores shall automatically be rendered null and void.
Further, I give the American Red Cross authority to forward and/or transmit this data to the New Hampshire Board of Nursing as well as my training program and/or test sponsor.

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:		