

**APPLICATION
APPROVED MEDICATION ADMINISTRATION PERSONNEL
(AMAP)**



Name _____ SS No. _____

Please list any previously used names here: _____

Home Address _____

Phone _____ Birth Date _____

Training Facility _____

Address _____ Phone _____

Employer _____ Phone _____

Address _____

Position held _____

Date AMAP Course was completed _____

RN AMAP Instructor _____

Candidate Signature _____ Date _____

AMAP RN Instructor Signature _____ Date _____

SOCIAL SECURITY NUMBER DISCLOSURE: Disclosure of your social security number should only be made if obtained from you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary for the purpose of internal identification, and may be used to verify information on your application, (class admissions and completions, competency evaluation testing, re-registration and reciprocity applications, etc), to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you. In accordance to the 42CFR 483.156(c), failure to provide requested information may result in your application being returned, a delay in processing, or your name not being placed on the West Virginia Nursing Assistant Registry.

Candidate: Make certain your instructor has the verification of your Criminal Background Check, CPR Certification, and First Aid Certificate in the event it is requested.

Mail with Request for Exams form to: PHD, LLC P.O. Box 399, Ona, WV 25545