

**WEST VIRGINIA  
APPROVED MEDICATION ASSISTIVE PERSONNEL  
(AMAP)**

**REQUEST FOR EXAMS**

NOTE: PLEASE PRINT THE FOLLOWING INFORMATION FOR EACH CANDIDATE. THE APPROVED AMAP RN MUST SIGN THIS FORM. THE FACILITY REQUESTING THE EXAMS MUST BE AN AMAP APPROVED FACILITY.

**NAME**

**SOCIAL SECURITY NUMBER**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the above named candidate(s) have/has successfully completed the approved AMAP training program and are/is eligible to take the required exam.

AUTHORIZED AMAP RN SIGNATURE \_\_\_\_\_

**Please print:**

AUTHORIZED RN NAME \_\_\_\_\_

AGENCY \_\_\_\_\_

FACILITY \_\_\_\_\_

**CURRENT FACILITY ID NUMBER** \_\_\_\_\_ (given by OHFLAC)

TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

MAIL COMPLETED APPLICATIONS WITH FEES TO PHD, LLC, P.O. BOX 399, ONA, WV 25545

REVISED 8-07