

**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.

<u>NAME</u>	<u>BIRTH DATE</u>	<u>SOCIAL SECURITY NUMBER</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above named candidate(s) are not listed on the WV NA Abuse Registry and have successfully completed the approved AMAP training program. I further certify that all required documentation has been reviewed, ie, CPR Certification and First Aid, High School Diploma/GED, and Criminal Background checks and are/is eligible to take the required exam.

AUTHORIZED AMAP RN SIGNATURE _____

AUTHORIZED RN NAME _____

AGENCY _____

FACILITY _____

CURRENT FACILITY ID NUMBER _____ (given by OHFLAC)

TELEPHONE _____

ADDRESS _____

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, or a delay in processing.

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