

**WEST VIRGINIA**  
**APPROVED MEDICATION ASSISTIVE PERSONNEL**  
**(AMAP)**  
**REQUEST FOR EXAMS**

NOTE: PLEASE TYPE 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**

**BIRTH DATE**  
(M/D/YYYY)

**SOCIAL SECURITY NUMBER**  
(XXX-XX-XXXX)

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**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.

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, National Sex Offenders Registry and Criminal Background check.

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

**PLEASE TYPE**

AUTHORIZED RN NAME \_\_\_\_\_ LICENSE # \_\_\_\_\_

AGENCY \_\_\_\_\_

FACILITY \_\_\_\_\_

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

TELEPHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

**Payment Options:**  Certified Check  Facility Check  Money Order

VISA  MC  DISCOVER

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_ CVV2 \_\_\_\_\_

Amount to charge card \_\_\_\_\_

Type name as it appears on credit card \_\_\_\_\_ Phone Number \_\_\_\_\_

Authorized Card Holder Signature \_\_\_\_\_ Date \_\_\_\_\_

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