

**WEST VIRGINIA  
REGISTERED NURSE AIDE EVALUATION  
APPLICATION**

**Part 1: General Information**

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First MI

Home Address  
(where you want your results sent) \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_ Birth date \_\_\_\_\_

**Part 2: Evaluation Choices**

<b><u>NEW CANDIDATE &amp; RESCHEDULING NO SHOWS</u></b>		<b><u>RE-TAKES</u></b>	
_____ Written & Skills Exams	\$100	_____ Written	\$42
_____ Oral & Skills	\$150	_____ Skills	\$58
		_____ Oral	\$92
<b><u>NURSE AIDE REFRESHER COURSE CANDIDATE</u></b>		_____ Written & Skills	\$100
_____ Written & Skills Exams	\$100	_____ Oral & Skills	\$150
_____ Oral & Skills	\$150		

**\*CORRECT FEES MUST ACCOMPANY THIS APPLICATION FOR CONSIDERATION**

**PART 3: SPONSOR INFORMATION (WHO IS PAYING FOR YOUR EXAM)\***

Sponsor Name \_\_\_\_\_ Sponsor Code \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

\*If you do not have a sponsor, write SELF in the blank.

**PART 4: TRAINING PROGRAM (WHERE YOU TOOK YOUR TRAINING PROGRAM)**

Training Program \_\_\_\_\_ Training Code \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

When did you complete this training course \_\_\_\_\_

**Part 5: Nurse Aide Refresher Course Information (required as applicable)**

Location of in-service \_\_\_\_\_ Date completed \_\_\_\_\_

**Part 6: Location of Evaluation**

First Choice \_\_\_\_\_ Date \_\_\_\_\_

Second Choice \_\_\_\_\_ Date \_\_\_\_\_

**Part 7: Special Testing Needs**

\_\_\_\_\_ I do not require special accommodations for the evaluation—*Sign the bottom of this page, then go to Part 8.*

\_\_\_\_\_ I DO require special accommodations for the evaluation\*

Please explain \_\_\_\_\_

\_\_\_\_\_

***If an oral version is required, make sure your sponsor requests an oral version two weeks before you want to test.***

\*Please attach proof from a profession who treats or specializes in treating your condition. This proof must include:

- Diagnosis of physical/mental condition
- Changes the professional thinks are needed

PHD and/or the Department of Health are not responsible for any costs incurred by you in obtaining this information.

To the best of my knowledge, the above information is truthful. I have not deliberately misled PHD or the Department of Health in any way.

\_\_\_\_\_  
**Candidate Signature**

\_\_\_\_\_  
**Date**

**Part 8: CHECKLIST**

**HAVE YOU:**

- ✓ Filled out the application completely?
- ✓ Signed the application?
- ✓ Included the correct fee? (no personal checks or cash)
- ✓ Included the correct documentation for special needs?

Then you're ready to mail this application\* to:

Professional Healthcare Development, LLC  
P.O. Box 399  
Ona, WV 25545

If you have questions regarding this application or the Evaluation, call PHD directly at (304) 733-6145.

\*You only need to mail Parts 1 – 7.