PEARSON VUE

Pennsylvania Nurse Aide Program

EXAMINATION REGISTRATION — *PLEASE PRINT LEGIBLY — USE INK ONLY*

You are responsible for completing this form if you wish to take the NNAAP™ Examination. You may receive assistance from your employer or someone from your training program to complete it. The personal information is used only to determine your eligibility to test. Failure to provide complete and accurate information may delay your nurse aide test or prevent your entry on the Registry.

If you wish to be enrolled in the Pennsylvania Nurse Aide Registry because you are listed on another state's nurse aide registry as active and in good standing – DO NOT COMPLETE THIS FORM. Contact Pearson VUE at 800-852-0518 to request a **Nurse Aide Registry Application for Enrollment by Reciprocity**. You may also download the Reciprocity Application from the Pearson VUE website at www.pearsonvue.com.

1. PERSONAL INFORMATION

Enter the requested information on the appropriate line. Enter your name as you would like it to appear on your nurse aide registration.

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ **Date of Birth:** ☐☐ / ☐☐ / ☐☐☐☐ (M M / D D / Y Y Y Y) **Gender:** ☐ FEMALE ☐ MALE

Disclaimer: Your Social Security number will be used for the purposes of positive identification relative to Registry-related information. Disclosure of your Social Security number is voluntary.

☐ If you prefer not to use your Social Security number and want an alternate ID assigned to you by the American Red Cross, please check this box.

Current Legal Name: DO NOT USE NICKNAMES

LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

FIRST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MI ☐

MAIDEN NAME *(if applicable)* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Mailing Address

STREET (number and name) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

APARTMENT NUMBER ☐☐☐☐☐☐

PO BOX ☐☐☐☐☐☐

CITY ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

STATE ☐☐

ZIP CODE *(MUST be completely filled out)* ☐☐☐☐☐ - ☐☐☐☐

Home Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ (AREA CODE)

Work Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ (AREA CODE)

Ethnic Group (*optional*). *Please mark only one.*

☐ American Indian/Alaskan Native ☐ Asian American ☐ Black (Non-Hispanic) African American
☐ Mexican American ☐ Other Hispanic ☐ White (Non-Hispanic) ☐ Other

2. REGISTRATION FOR EXAM AND FEES *(check only one box)*

Check the box indicating the exam that you need to take. If you are applying for the first time, you must take both the Written (or Oral) Examination and the Skills Evaluation. You **must** choose between the Written Examination and the Oral Examination; you may not register for both. (For more information about the Oral Examination, refer to the Pennsylvania Nurse Aide Candidate Handbook.)

1. ☐ Written Exam and Skills Evaluation . . $102.00
2. ☐ Oral Exam and Skills Evaluation $112.00
3. ☐ Written Exam ONLY $41.00
4. ☐ Oral Exam ONLY $51.00
5. ☐ Skills Evaluation ONLY $61.00

Amount enclosed: $ ☐☐☐.☐☐

Examination fee: Must be paid in the form of a certified check, company check, or money order, made payable to "American Red Cross" (ARC). **No personal checks or cash accepted. Fees are non-refundable once submitted because they cover the administration costs of registration and testing.**

IF YOU ARE EMPLOYED BY A NURSING FACILITY, THE NURSING FACILITY MUST PAY THE EXAMINATION FEES.

3. ELIGIBILITY ROUTE INFORMATION *(check only one box)*

☐ **E-0 — I have completed a nurse aide training program,** approved by the Pennsylvania Department of Education, within the last twenty-four (24) months.
  ☐ *I have enclosed a photocopy of my nurse aide training completion certificate, issued within the last twenty-four (24) months by an approved Pennsylvania nurse aide training program.*

☐ **E-1 — I am a student nurse** and have been approved to test by the Pennsylvania Department of Education.
  ☐ *I have enclosed a photocopy of my approved application to test issued by the Pennsylvania Department of Education.*

Eligibility Route Inform ation continues on reverse side

☐ **E-2 — I received my nurse aide training in a state other than Pennsylvania** and have been approved to test by the Pennsylvania Department of Education.

☐ *I have enclosed a photocopy of my approved application to test issued by the Pennsylvania Department of Education.*

☐ **E-3 — My Pennsylvania nurse aide registration has lapsed** because I have not worked providing nursing-related services for at least twenty-four (24) consecutive months. (An E-3 candidate has one (1) opportunity to successfully pass the NNAAP™ Examination; if the examination is failed, the candidate must complete nurse aide training again and reapply under eligibility E-0.)

☐ **I have enclosed a photocopy of my Pennsylvania Nurse Aide Registration Card.**

PA Nurse Aide Registration ID Number: ☐☐☐☐☐☐☐☐ **Registration Expiration Date:** ☐☐ / ☐☐ / ☐☐☐☐ (M M / D D / Y Y Y Y)

☐ **E-4 — I am a certified nurse aide on another state's nurse aide registry but my certification has lapsed** because I have not worked providing nursing-related services for at least twenty-four (24) consecutive months. (An E-4 candidate has one (1) opportunity to successfully pass the NNAAP Examination; if the examination is failed, the candidate must complete nurse aide training again and reapply under eligibility E-0).

☐ **I have enclosed a photocopy of my out-of-state nurse aide certification documentation.**

State Certified In: ☐☐ **Registration ID Number:** ☐☐☐☐☐☐☐☐ **Registration Expiration Date:** ☐☐ / ☐☐ / ☐☐☐☐ (M M / D D / Y Y Y Y)

4. TRAINING PROGRAM INFORMATION

Enter the name of the state-approved training program where you completed your nurse aide training. If your training program and employer are the same, print "CURRENT EMPLOYER" in the space labeled "Name of Training Program". Enter the code provided by your training program. If you are a student nurse or a practical nurse, or you received your nurse aide training out of state, you must submit an approval letter from the Pennsylvania Department of Education (717) 783-6974 or (717) 772-0814 instead of a training certificate. Eligibility routes E-3 and E-4 do not require a letter of approval. If you fall under one of the following, please use the code indicated to the right: **Student Nurse.....3959991** **Trained out of state.....3959999**

Name of Training Program: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Training Program Code: 3 9 5 ☐☐☐☐ **Date Completed Training:** ☐☐ / ☐☐ / ☐☐☐☐ (M M / D D / Y Y Y Y)

5. PAYMENT RECEIPT

Did you pay the cost of this examination with your personal funds? ☐ **Yes** ☐ **No**

6. TEST SITE CODE AND TEST LOCATION

Check the box indicating where you will be testing—either at a Permanent Test Site or at an In-Facility Test Site.

☐ **Permanent Test Site**—*Provide the code and city of the test site where you prefer to test. (See the Pennsylvania Nurse Aide Candidate Handbook for test site locations and codes.) Every effort will be made to schedule your preferred test date. If that date is not available, you will be scheduled for the next available date at the test site that you indicated. You will be notified by mail of your scheduled examination date.*

Test Site Code: R T S 3 9 ☐☐☐☐ **Test Site City/Town:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Indicate your preferred test date (current testing schedule is available at www.pearsonvue.com): ☐☐ / ☐☐ / ☐☐☐☐ (M M / D D / Y Y Y Y)

☐ **In-Facility Test Site**—*In-Facility testing requires a minimum of four (4) applicants per examination date, or payment for four (4) applicants, if less than four (4) individuals are testing. All application forms for in-facility testing must be mailed together, along with the correct payment.*

Facility Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Facility City/Town: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PLEASE REVIEW YOUR REGISTRATION FORM. BE SURE IT IS CORRECT AND ACCURATE. IF YOUR FORM IS INCOMPLETE, OR YOU HAVE NOT ENCLOSED THE CORRECT EXAMINATION FEES, OR YOU HAVE NOT ATTACHED A COPY OF YOUR TRAINING CERTIFICATE AND/OR APPROVAL LETTER, YOUR FORM WILL BE RETURNED TO YOU. THIS WILL DELAY YOUR REGISTRATION. THE AMERICAN RED CROSS IS NOT RESPONSIBLE FOR MISDIRECTED MAIL.

7. REGISTRANT CERTIFICATION

I hereby certify that the information provided on this registration form is true and accurate, and that I am the person whose name appears on the form.

SIGNATURE DATE

Mail your completed application, including all required documentation and fees, to:

If using US Mail service, mail to:
American Red Cross
PO Box 5875
Harrisburg, PA 17110

If using an overnight courier service, send to:
American Red Cross
1804 North Sixth Street
Harrisburg, PA 17102

For test scheduling inquiries, please call: (800) 795-2350.

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