# *COVID-19 MODIFIED KENTUCKY MEDICAID NURSE AIDE TEST ROSTER*

Revised 6/10/2020

**Training Provider** ____________________________________________

**Address** ____________________________________________

____________________________________________

**Phone** ______________________ **Contact Person** ____________________

**Requested Test Date** ____________ **Actual Test Date** ____________ **Test Center Name** ________________

**Facility No.** ____________

**Written Test Form** ____________

**Form** ____________

**Testing Region No.** ____________

**TRAINING DOCUMENTATION FOR INDIVIDUALS TO BE PARTIALLY TESTED**

I certify that the individuals listed on this roster to take the written test have successfully completed the fifty-nine (59) hours of didactic/lab instruction of an approved Nurse Aide Training Program, that the training approval number for that program is listed, and that appropriate documentation is on file. I certify that individuals listed on this roster to take the performance test have successfully completed the sixteen (16) hours of supervised clinical instruction in compliance with DMS guidelines during the COVID-19 declared state of emergency. Individuals will have one (1) year to successfully complete both the written and the performance. I certify that the individuals submitted for testing with an impairment (reading, sight, hearing, or language) have been assessed by this facility and deemed capable of performing the job duties of a Nurse Aide.

**Training Provider Program Coordinator Signature** ______________________________________

| Test Candidates<br>Last Name / First Name | Social Security Number | ID (√) | Training Completion Date | Signature On Test Date | Training Provider Approval Number | Status:<br>004=written<br>005=practical | Cost |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |

TEST CANDIDATE RELEASE STATEMENT I acknowledge that I have read the Medicaid Nurse Aide Testing Procedures Manual and agree to abide by the rules and conditions in the manual as attested by my signature, above.

| **Test Admin. Signatures** | |
|---|---|
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| | |
| **Regional Coordinator Signature** | |