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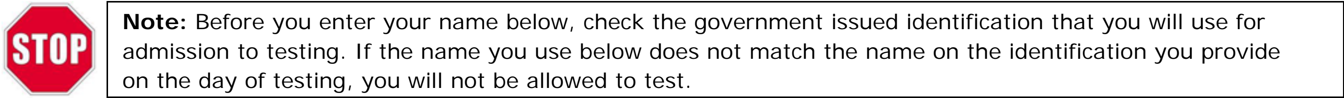
PROMETRIC

Connecticut Nurse Aide Registry Application

Please Print or Type Clearly and Neatly.

Part A. Candidate Information



Note: Before you enter your name below, check the government issued identification that you will use for admission to testing. If the name you use below does not match the name on the identification you provide on the day of testing, you will not be allowed to test.

Last Name	First Name	Middle Initial	Maiden Name (if applicable)
Street Address (including Apt. number or P.O. Box, if applicable)			Social Security Number* - -
City	State	ZIP Code	Email Address

Daytime Phone Number (including area code) ( )	Evening Phone Number (including area code) ( )

☐ I am requesting Special Accommodations and have included the necessary documentation with this application	Gender (check one) ☐ Female ☐ Male	Date of Birth - -

Part B. Exam Selection and Fees (If the state is paying the exam fees, Part E must be completed.)

☑	**First-Time Tester**	**Fee**	**Total**
	Written Test and Clinical Skills Test	$110	$
	Oral Test and Clinical Skills Test	$120	$
☑	**Retester**	**Fee**	
	Clinical Skills Test ONLY	$65	$
	Written Test ONLY	$45	$
	Oral Test ONLY	$55	$
☑	**Other**	**Fee**	
	Route 5-trained and took state exam in last 24 months	$55	$
	Route 6	$55	$
	Route 7 –Reciprocity	$55	$
	Rescheduling/No Show Fee	$25	$
		Total Fee	**$**

Payment: Fees may be paid by cashier's check, money order, MasterCard or Visa. Make checks payable to Prometric. **Personal checks and cash are not accepted. Registration fees are not refundable.** To pay by credit card, please complete the information below.

Card Type (Check One) ☐ MasterCard ☐ Visa	Card Number	Expiration Date

Name of Cardholder (Print)	Signature of Cardholder

Part C. Eligibility Route

(See explanation of routes in this bulletin beginning on Page 2.)

☑	Route	Document(s) needed
	1 - New Nurse Aide	Copy of training program completion certificate from a Connecticut-approved nurse aide training program.
	2 - Nurse or Student Nurse	Copy of current RN or LPN license OR copy of nursing school transcript.
	3 - Out-of-State Nurse Aide	Copy of completion certificate from a state-approved training program.
	4 - Lapsed Nurse Aide	Copy of Connecticut Nurse Aide Registration Card OR Registration #: ____________________________ Expiration Date: ___________
	5 - Completed Nurse Aide Training and took state exam within the last 24 months	Copy of Connecticut Nurse Aide Certification of course completion.
	6 - Completed Nurse Aide Training more than 24 months ago	Copy training program completion certificate and proof of employment.
	7 - Reciprocity	Copy of current certificate or a letter from the state registry verifying your certificate is current and in good standing.

Part D. Training Program Affidavit/Completion Certificate

If you are applying using Route 1, Part D must be completed.

Name of Training Facility	City
Training Program Code _____ _____ _____ _____	Date Training Completed - -
I certify that this applicant has successfully completed a state-approved nurse aide training program	
Training Instructor Signature	
Instructor Title	Date - -

Part E. Regional Test Site Information

Prometric will make every effort to schedule you in the location of your choice. Site locations and schedules are subject to change. For the most current scheduling information, check online at www.prometric.com/NurseAide/CT, or call 866.499.7485. Please select a preferred regional site from the regional test site list posted on **www.prometric.com/NurseAide/CT** and list the name of the facility here_______________________________.

Part F. In-Facility Testing

Please fill in the test date and test site code supplied by Prometric. In-facility testing requires a minimum of eight applicants per examination date, or payment of eight applicants, if less than eight are testing. All application forms for In-Facility testing must be mailed together along with the correct payment.

Facility Name	City
Test Site Code _____ _____ _____ _____ _____	Test Date - -

Part G. Applicant's Affidavit

I understand that I am responsible for making sure all of the information provided in this application is completely true and correct. I understand that if information given is not true, my registration status as a nurse aide may be jeopardized.
I understand that if I pass both parts of the Connecticut Nurse Aide Examination, I will be placed on the Registry.

Applicant's Signature Date

Candidate Release Statement

I understand that I may be asked to play the part of the resident for another candidate on exam day. I do not have any physical, medical or other condition that would be affected in any way by my participation in the exam. I agree that I am responsible for my own personal safety both while taking the exam and acting as a resident. I hereby release Prometric, the Connecticut Department of Public Health, and their agents and assigns from any responsibility or liability for any claim or damage that may result from my participation in the examination.

Printed Name of Candidate	Signature	Date

*If you left the Social Security Number field blank, please explain why.

If testing at a Facility: Provide this completed form, along with all necessary documents to your training coordinator (do not send it to Prometric).

If testing at a Regional Test Site: Submit this completed form, along with all necessary documents and fees to:

By Mail: Prometric, Attn: CT Nurse Aide Testing Program, 1260 Energy Lane, St. Paul, MN 55108.

By Fax (if paying by credit card): 800.813.6670.

Additional Information

If you have read this bulletin and still have questions, please contact:

Prometric
1260 Energy Lane, St. Paul, MN 55108
Phone: 866.499.7485
Fax: 800.813.6670
www.prometric.com/NurseAide/CT