

3. ELIGIBILITY ROUTES (check the appropriate box)

E-1 — NURSING ASSISTANT

You have completed a Rhode Island Department of Health-approved nursing assistant training program.

NOTE: You are allowed one (1) year from the date your training began to pass the nursing assistant examination; otherwise, you will be required to retrain before you will be allowed to test again.

E-2 — NURSING STUDENT

You are actively matriculated in a nursing program and have completed a minimum of two (2) clinical courses.

4. RHODE ISLAND NURSING ASSISTANT TRAINING PROGRAM AFFIDAVIT/COMPLETION CERTIFICATION

Enter the nursing assistant training program name for the Rhode Island Department of Health state-approved nursing assistant program. Also enter the nursing assistant training program code and the training start date. Please have this section signed by your nursing assistant training program instructor or authorized representative.

Name of Training Program:

Training Program Code:

Date Training Began: - -
MONTH DAY YEAR

I certify that this applicant has successfully completed a Rhode Island Department of Health state-approved nursing assistant training program.

TRAINING INSTRUCTOR'S SIGNATURE (or authorized representative)

TITLE

DATE

5. TEST LOCATION PREFERENCE

Using the Regional Test Sites list below, fill in the **first and second choices** of the test site at which you prefer to test.

Community College of Rhode Island:

- Knight Campus..... RTS 4001
- Flanagan Campus..... RTS 4002
- Liston Campus RTS 4003
- Newport Campus..... RTS 4005

American Safety Program & Training, Inc.:

- American Safety Campus (Providence)*RTS 40099

FIRST TEST SITE PREFERENCE:

Test Site Code: -

Test Site City/Town:

SECOND TEST SITE PREFERENCE:

Test Site Code: -

Test Site City/Town:

6. EXAM DATE PREFERENCE

Indicate your first and second choice of an examination date. Check the Rhode Island RTS Schedule at www.pearsonvue.com for the current schedule of examination dates. Note: The RTS Schedule is subject to change.

FIRST EXAM DATE PREFERENCE: - -
MONTH DAY YEAR

SECOND EXAM DATE PREFERENCE: - -
MONTH DAY YEAR

7. 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 is given that is not true, my license status as a nursing assistant may be jeopardized. I understand that if I pass both parts of the NNAAP Examination I will be placed on the Registry.

SIGNATURE

DATE

Either your nursing assistant training program, your employer, or you must mail your completed application, required documentation, and appropriate fee together in one envelope.

MAIL TO:

RI NNAAP Program
Community College of Rhode Island
Center for Workforce and Community Education
1762 Louisquisset Pike
Lincoln, RI 02865

***If testing at the American Safety Program & Training, Inc.,**

MAIL TO:

RI NNAAP Program
American Safety Programs & Training
150 Niantic Avenue
Providence, RI 02907