

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES  
**ALLIED HEALTH VERIFICATION**  
 for 90-hour Kansas Nurse Aide Certification

Complete this form and attach the following:

- < **copy** of identification with current name & social security number (such as driver's license, social security card)
- < an application fee of \$20.00 (check or money order)
- < **an OFFICIAL** transcript from **current** training (training must be within the last 24 months) program or a copy of professional license (if expired, must be within the last 24 months)

**All fees are NOT refundable**

**Candidate Information**

**Name** \_\_\_\_\_  
 Last First MI Other (maiden/surname)

**Social Security Number** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Birth date** \_\_\_/\_\_\_/\_\_\_ **Sex** \_\_\_ Male \_\_\_ Female

**Address** \_\_\_\_\_  
 Street City State Zip

**Phone Number** Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

**Please mark the highest level of education received:**

- (N) No high school
- (H) High school diploma or GED
- (L) Licensed Practical Nurse
- (D) Diploma Nurse (RN)
- (A) Associate Degree
- (B) Bachelor's Degree
- (M) Master's Degree
- (E) Education Specialist
- (P) PhD

**Check which applies (a suspended or revoked licensure will make you ineligible for the test):**

- |                               |           |                                     |
|-------------------------------|-----------|-------------------------------------|
| Training                      |           | Licensure                           |
| <input type="checkbox"/> RN   | <u>OR</u> | <input type="checkbox"/> RN State   |
| <input type="checkbox"/> LPN  |           | <input type="checkbox"/> LPN State  |
| <input type="checkbox"/> LMHT |           | <input type="checkbox"/> LMHT State |

**Check Test Site Preference:**

- |                                      |                                      |  |   |                                   |  |
|--------------------------------------|--------------------------------------|--|---|-----------------------------------|--|
| <input type="checkbox"/> Atchison    | <input type="checkbox"/> Concordia   | <input type="checkbox"/> Great Bend      | <input type="checkbox"/> Kansas City CC | <input type="checkbox"/> Parsons  | <input type="checkbox"/> Junction City     |
| <input type="checkbox"/> Beloit      | <input type="checkbox"/> Dodge City  | <input type="checkbox"/> Hays            | <input type="checkbox"/> Donnelly - KC  | <input type="checkbox"/> Pratt    | <input type="checkbox"/> Johnson County CC |
| <input type="checkbox"/> Burlingame  | <input type="checkbox"/> El Dorado   | <input type="checkbox"/> Hutchinson      | <input type="checkbox"/> Liberal        | <input type="checkbox"/> Salina   |  |
| <input type="checkbox"/> Chanute     | <input type="checkbox"/> Emporia     | <input type="checkbox"/> Independence    | <input type="checkbox"/> Manhattan      | <input type="checkbox"/> Topeka   |  |
| <input type="checkbox"/> Coffeyville | <input type="checkbox"/> Fort Scott  | <input type="checkbox"/> Iola            | <input type="checkbox"/> National Am. U | <input type="checkbox"/> Wichita  |  |
| <input type="checkbox"/> Colby       | <input type="checkbox"/> Garden City | <input type="checkbox"/> Kansas City ATS | <input type="checkbox"/> Pittsburg      | <input type="checkbox"/> Winfield |  |

**Candidate's Signature**

I do hereby attest that the information supplied in this application and any attachments is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and any attachments. *I have attached a **copy** of an identification document with my current name, social security number, and an official transcript or copy of professional license.*

\_\_\_\_\_  
 Candidate's Signature Date

Return this form and attachments to: Health Occupations Credentialing, KDADS  
 612 S KANSAS AVE  
 Topeka KS 66603-3404

KDADS USE ONLY: Approval Date	Test Date
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Candidate, **please note:**

1. You must present two forms of identification, with one being picture I.D., to be admitted to test.
2. You must be able to provide your social security number on the test for identification.
3. **YOU MUST BE ON TIME.**
4. If you are late, or fail to appear for your scheduled test, you must call (785) 296-6958 to request a rescheduling form which requires an additional fee of \$20.00.
5. You will receive a **Approval to Test** notice that will allow a nursing facility to employ you as a Nurse Aide Trainee II for a single four month period beginning on the approval date.
6. Nurse aide certificates are issued to those who achieve a score of at least seventy five percent (75%) on the nurse aide test.
7. The nurse aide test may be taken **only one time** based on training or licensure. Any candidate who fails the test on the first attempt **must enroll in a state-approved nurse aide training course.** You then have two remaining opportunities to pass the test within one year from the approval date designated above.
8. Test scores may be requested by writing to the address listed below.

**Health Occupations Credentialing, KDADS**  
**\*%& S KANSAS AVE**  
**Topeka, Kansas 66603-3404**  
**(785) 296-6958**

Web site: [www.kdads.ks.gov](http://www.kdads.ks.gov)