KANSAS DEPARTMENT for AGING AND DISABILITY SERVICES

RESCHEDULING FORM

Check type of exam. Enclose non-refundable fee of $20.00: Payable to KDADS (check or money order).

___ 90-Hour CNA Test  ___ 20-Hour Home Health Aide Test

Candidate Information

A COPY OF IDENTIFICATION WITH YOUR SOCIAL SECURITY NUMBER MUST BE ON FILE.

Name ____________________________________________  ____________________________________________

Last                                                         First                                             MI

Other Names Used

If name change, submit documentation (i.e.: marriage license, divorce decree, new ss card).

Social Security Number _______ - _______ - _______  Birth date _____/_____/______  Sex  ____Male  ____Female

Address ____________________________________________  ____________________________________________

Street  City  State  Zip

Phone Number  Home: (_____)____________________________  Cell: (_____)____________________________

EMAIL:____________________________________________  Preferred Method of Approval Letter: ___Mail  ___Email

Retake (Failed the test one or more times): ___Yes  ___No  Do not use this form if currently enrolled in a course or if you have failed the state test three times within a year from the beginning date of your course.

TEST SITE PREFERENCE (Please check the appropriate site):

___ Andover  ___ Concordia  ___ Hutchinson  ___ Lawrence  ___ Parsons  ___ Winfield

___ Atchison  ___ Dodge City  ___ Independence, KS  ___ Lenexa  ___ Pratt

___ Beloit  ___ Emporia  ___ Iola  ___ Liberal  ___ Salina

___ Burlingame  ___ Fort Scott  ___ Junction City  ___ Manhattan  ___ Topeka

___ Chanute  ___ Garden City  ___ KC KS Community College  ___ Merriam  ___ Wichita/Allied

___ Coffeyville  ___ Great Bend  ___ KC KS Delores Homes  ___ Olathe  ___ Wichita/Bethel

___ Colby  ___ Hays  ___ KC KS Donnelly  ___ Pittsburg  ___ Wichita/WSU Tech

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 and to send my test results to my instructor.

____________________________________________  ____________________________

Candidate’s Signature  Date

Mail this form and attachments to:  KDADS/Health Occupations Credentialing

503 S. Kansas Avenue

Topeka KS 66603

Phone number: (785) 296-6958

Web site: www.kdads.ks.gov/hoc  Revised 01/03/2018
Candidate, **PLEASE NOTE:**

1. You must present two forms of identification, with one being picture I.D., to be admitted to test. **There will be an additional fee to be paid to the test site for testing.**

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. Each candidate has a total of three attempts per year from the beginning date of the course to successfully complete the written state test.

6. If the test is not passed within one year from the starting date of the initial course, the course must be retaken to be eligible to retake the test.

7. **ALL FEES ARE NOT REFUNDABLE.**

8. The time limit is two hours unless other accommodations to address a disability are requested and approved (no oral tests are given for the home health aide test).

9. If a special accommodation is needed, you **MUST** submit the candidate’s "**Accommodation Request Evaluation Form**" with this application.

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