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 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 ( )__________________________

EMAIL:__________________________________________

Preferred Method of Approval Letter: ___Mail ___Email

Please mark the highest level of education received:

__(N) No high school  __(D) Diploma Nurse (RN)  __(M) Master’s Degree

__(H) High school diploma or GED  __(A) Associate Degree  __(E) Education Specialist

__(L) Licensed Practical Nurse  __(B) Bachelor’s Degree  __(P) PhD

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

Training  Licensure

__RN ___ OR __RN State

__LPN ___ __LPN State

__LMHT ___ __LMHT State

Check 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 __KS KS Donnelly __Pittsburg __Witchita/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. 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

Mail this form and attachments to: Health Occupations Credentialing, KDADS
503 S Kansas
Topeka KS 66603-3865

KDHE USE ONLY: Approval Date Test Date
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) 296-1250 to request a rescheduling form which requires an additional fee of $20.00.

5. You will receive an Approval to Test notice that will allow a home health agency to employ you as a Trainee II for a single three month period beginning on the approval date.

6. Home health aide certificates are issued to those who achieve a score of at least 22 on the home health aide test.

7. The home health 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 training course.** You then have two remaining opportunities to pass the test within one year from the approval date designated above.

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