WEST VIRGINIA APPROVED MEDICATION ASSISTIVE PERSONNEL (AMAP)REQUEST FOR EXAMS

Request for Exams and AMAP Application must arrive at PHD's office with payment seven business days prior to requested test date
HAND WRITTEN FORMS NOT ACCEPTED

NAME	SOCIAL SECURITY NUMBER XXX-XX-XXXX	DATE OF TEST	TIME OF TEST

SOCIAL SECURITY NUMBER DISCLOSURE: Disclosure of your social security number should only be made if obtained from you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary for the purpose of internal identification, and may be used to verify information on your application, (class admissions and completions, competency evaluation testing, re-registration and reciprocity applications, etc), to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.
In accordance to the 42CFR 483.156(c), failure to provide requested information may result in your application being returned, or a delay in processing.

I certify that the above named candidate(s) are not listed on the WV NA Abuse Registry and have successfully completed the approved AMAP training program. I further certify that all required documentation has been reviewed, ie.WV CARES Check, CPR Certification and First Aid, High School Diploma/GED, National Sex Offenders Registry and Criminal Background check.

AUTHORIZED AMAP RN SIGNATURE_____ DATE _____

AUTHORIZED RN NAME_____ LICENSE #_____

FACILITY_____

CURRENT FACILITY ID NUMBER **WV**_____ (given by OHFLAC)

TELEPHONE_____ Fax_____ Email_____

ADDRESS_____

_____

Tests to be Administered By: _____

Location of Testing Site: Street address _____

City_____ **State** _____

Test registration information will be emailed to AMAP RN five business days prior to testing.

Payment Options ◯ **AMX** ◯ **Certified Check** ◯ **Facility Check** ◯ **Money Order** ◯ **VISA** ◯ **MC** ◯ **DISCOVER**

Credit Card #_____**Expiration Date (MM/YY)**_____ **Card ID#**_____

Amount to charge card _____

Type name as it appears on credit card_____

Credit Card Mailing Address Street_____

City _____ **State**_____ **Zip Code**_____

Authorized Card Holder Signature_____**Date**_____ **Phone number**_____

MAIL OR FAX WITH COMPLETED APPLICATIONS AND FEES TO PHD, LLC, P.O. BOX 399, ONA, WV 25545 FAX 304-733-6146
REVISED 3/2018