STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Maine Registry of Certified Nursing Assistants (CNA)

Application for CNA Competency Testing

SECTION 1: Applicant Information			
Sponsor Name (Educational Delivery System):			
Administrator of Program Name:	Administrator of Program Signature:		Date:
Telephone No.: ( )	Fax No.: ( )	Email:	
Primary Instructor Name:	Primary Instructor Signature:		Date:

SECTION 2: Fees	
APPLICATION FOR CNA COMPETENCY TESTING	
Testing fee = $45.00 x _____ (Number of tests)	$ _____
Make check or money order payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Check/Money Order enclosed: =**	**$ _____**

SECTION 3: Testing Information			
Total Classroom Hours:	Total Laboratory Hours:	Total Clinical Hours:	
Program Begin Date:	Program End Date:	Test Date:	
Proctor Name:			
Test Location:			
Mailing Address to send test(s) to:			
City:	State:	Zip:	County:

Satisfactorily completed SKILLS CHECKLISTS must be submitted prior to the release of test scores.
Please submit this form and the Roster Sheet (Appendix A), ***at least two (2) weeks prior*** to the exam date to the address below.

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
CNA Competency Testing
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-2281 Fax: (207) 287-2673 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: robert.e.carr@maine.gov

Office Use Only: Check# _____ MO # _____ Amount $_____ Initials: _____
Program No: _____ Date Tests Sent: _____ Date Tests Returned: _____ Test Color: _____ Mail Receipt No: _____

Competency Testing Roster Sheet

	Last Name, First Name, Middle Initial	Social Security Number	Date of Birth
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Please use additional sheets if necessary.