

# REGISTRATION FOR WRITTEN EXAMS

(Medication Aide, Administrator and  
Alternative registration forms must be  
mailed along with appropriate fee(s).

Exams are for the **Adult Care Licensure Section for staff or potential staff of family care homes and adult care homes (assisted living)**. Read instructions before completing the registration form. Complete pages 5 & 6. If you have any questions, you may contact the Testing Unit at (919) 855-3793. Failure to complete the registration form may cause delays with scheduling the exam(s) of your choice. **You will not be able to enter information online. Please print the registration form in order to complete it. If you are registering for more than one exam, a registration form and payment of fee must be completed for EACH exam.**

**A. EXAM  
REQUESTED**



**1. MEDICATION  
AIDE**

**2. ADMINISTRATOR  
3. ALTERNATIVE**

**(Circle number {1,2,3} beside the exam you want to register for)**

### EXAM FEES

<b>(1) Medication Aide: \$25.00</b>	<b>(2) Administrator: \$50.00</b>	<b>(3) Alternative: No Charge</b>
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Payment must be made in the form of a money order or certified check made payable to "DHSR". Personal or company/agency checks are not accepted forms of payment. Fees are non-refundable and non-transferable once submitted to DHSR. Payment will NOT be accepted at testing locations.

**PLEASE PRINT CLEARLY - ITEMS WITH AN \* MUST BE COMPLETED**

<b>* (1) Last Name</b>	<b>First Name</b>	<b>MI</b>

(Use your legal name as listed on your driver's license and/or Social Security card.)

### \* (2) Your Complete Mailing Address:

<b>Street:</b>	<b>Apt. #:</b>
<b>PO Box (if preferred):</b>	
<b>City:</b>	<b>State:</b>
<b>Zip:</b>	

### \* (3) Social Security Number [\*\*Note]

### \* (4) Gender (circle one): Male - Female

[\*\*]The SS# is used to register you for an exam and to verify your test results. Incompletion of the SSN may delay your registration for a preferred test site.

### \* (5) Date of Birth: Month: \_\_\_\_\_ Year: \_\_\_\_\_

### \* (6) Phone Number (home or cell):

### (7) County in which you reside:

(Include your 3 digit area code)

**LEAVE BLANK**

### \* (8) Highest Education Level (circle one): [1] Less than HS [2] HS Diploma [3] GED [4] Alternative Exam [5] Associates Degree [6] Bachelors Degree [7] Graduate Work

**If you are registering for the Administrator or Alternative exams, numbers 9 through 13 should not be completed. Skip to 14 and finish completing.**

**\*(9) Aide Training (circle one):**

[1] 20/25 hrs      [2] 40/45 hrs      [3] 75/80 hrs      [4\*\*] NA      [5] Other      [6] None  
 \*\*{4} certified nursing assistant

**\*(10) Medication Training (circle one):**      [1\*\*] Class      {2\*\*} Study Guide      [3] Both      [4] None

\*\*{1} may include 5-10-hr or 15-hr Medication Training Requirement      \*\*[2] [www.ncdhhs.gov/dhsr/acls/pdf/medstudy.pdf](http://www.ncdhhs.gov/dhsr/acls/pdf/medstudy.pdf)

**\*(11) Currently Employed in a Facility (circle one):**      YES      NO

**\*(12) Facility Employment (circle one):**

[1] FCH      [2] ACH      [NH]      [4] None / Other  
 Family Care Home      Adult Care Home (assisted living)      Nursing Homes

**\*(13) Job Title in Facility (circle one):**      [1] Administrator      [2] Supervisor      [3] Aide      [4] Other

**\*(14) Exam Codes (please enter 3 choices):** Links are provided below for access to Exam Codes.

Administrator and Alternative: [www.ncdhhs.gov/dhsr/acls/](http://www.ncdhhs.gov/dhsr/acls/) {Administrator Certification & Forms}

Medication Aide Testing website: <https://mats.dhhs.state.nc.us/> {Test Site Locations}

<b>1st:</b>	<b>2nd:</b>	<b>3rd:</b>	<b><u>(Failure to complete exam choices may delay your registration for a preferred test site).</u></b>
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**\*(15) Signature of Applicant:**

**I certify that this application is true and correct to the best of my knowledge. I have read and understand the policies and procedures for testing.**

**DATE:**

**(16) Provide your Email Address, if applicable (please print clearly):**

**(17) Provide facility name, phone and Fax number, if applicable:**

[Alternate means of contact if unable to reach you with the number listed in #6 or info in #16 ]

**Facility:**      **Contact:**

**Phone:**      **Fax:**

**ONCE YOU HAVE COMPLETED PAGES 5 & 6, ENCLOSE YOUR TESTING FEE(S) WITH YOUR REGISTRATION(S) & RETURN ALL TO ONE OF THE ADDRESSES LISTED BELOW:**

REGULAR MAIL (USPS)	EXPRESS MAIL (FedEx or UPS)
<b>NC Division of Health Service Regulation            Health Care Personnel Education &amp;            Credentialing Section - Testing Unit            2709 Mail Service Center            Raleigh NC 27699-2709</b>	<b>NC Division of Health Service Regulation            Health Care Personnel Education &amp;            Credentialing Section - Testing Unit            801 Biggs Drive - Brown Bldg.            Raleigh NC 27603</b>

OFFICE USE ONLY
Mailed: _____
Faxed: _____
Emailed: _____
Notes: _____

(This agency is not responsible for lost, delayed or misdirected mail).