Verification of Direct Care Worker Testing

This is a request for testing information; it is not a reference check.

FAX

From:

Organization Name:_____ FAX Number: _____

Address: _____

Name of Person Requesting Information: _____

Title: _____ Phone Number: _____

Date:_____ Signature: _____

Employee Information:

Name:_____

Day and Month of Birth:_____ Last 4 digits of Social Security Number:

Consent to release information: *I give permission to release information about my testing.*

Date: _____ Signature: _____

Organization Providing the Information:

Organization Name:_____ FAX Number: _____

Address:_____

Name of Person Providing Information: _____

Title: _____ Phone Number: _____

Date: _____ Signature: _____

Testing Information:

Please fill in the date of the test(s) completed, whether the test score was passing (P) or failing (F) and initial each line. Please put a line through any modules not completed. **A <u>DCW</u> must have a score of 80% or more for each written (knowledge) test and all (100%) of skills demonstrations completed successfully to be considered as passing. A <u>DCW Trainer</u> must have a score of 92% or more for each written test and all (100%) of skills demonstrations completed successfully to be considered as passing.**

If you have no records of training or testing for this applicant, please fill out the first line below.

We have no record of training/testing for this applicant. _____
(date / signature)

Level I	**Date Completed**	**Pass/Fail**	**Initials**
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____

Level II	**Date Completed**	**Pass/Fail**	**Initials**
Aging & Physical Disabilities			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____
Developmental Disabilities			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____