ACOM XXX -- Attachment A

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 2 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 student 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.** 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)

	Date Completed	**Pass/Fail**	**Initials**
Level I			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____
Level II			
Aging & Physical Disabilities			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____
Developmental Disabilities			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____
Alzheimer's Disease/Dementia			
Written Test	_____	_____	_____
Skills Demonstration	_____	_____	_____
Other (write in, e.g. Article 9, CIT, CPR, First Aid, and so forth)			
_____	_____	_____	_____
_____	_____	_____	_____