NEW JERSEY ASSISTED LIVING ADMINISTRATOR/ NEW JERSEY MEDICATION AIDE EXAMINATION ELIGIBILITY FORM

To become eligible to test, you must provide a valid certificate of completion, along with this eligibility form. You may mail or fax this to:

PSI Regional Processing Office
IBIS Plaza South
3525 Quakerbridge Road, Suite 1000
Hamilton Township, NJ 08619
877-774-4243 * FAX 609-588-5461

1. **Legal Name:** Last Name First Name M.I.
2. **Social Security:** - - *(FOR IDENTIFICATION PURPOSES ONLY)*
3. **Mailing Address:** Number, Street Apt/Ste
   City State Zip Code -
4. **Telephone:** Home - Office -
6. Email: _____
7. **CNA / HHA Certificate #:** _____
8. **Examination:** (Check one) ☐ Assisted Living Administrator $53 ☐ Medication Aide $53
   (Check one) ☐ FIRST TIME ☐ RETAKE
9. Birth Date MM DD YY
10. **Total Fee $_____.** You may pay by credit card, money order, company check or cashier's check. Cash and personal checks are not accepted.)

    If you are paying by credit card, check one: ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover

    Card No: _____ Exp. Date: _____

    Card Verification No: _____

    The card verification number may be located on the back of the card (the last three digits on the signature strip) or on the front of the card (the four digits to the right and above the card account number).

    Billing Street Address: _____ Billing Zip Code: _____

    Cardholder Name (Print):_____ Signature:_____
11. **I am faxing the Special Arrangement Request (at the end of this bulletin) and required documentation.** ☐ Yes ☐ No
12. **Affidavit:** *I certify that the information provided on this registration form (and/or telephonically to PSI) is correct. I understand that any falsification of information may result in denial of certification. I have read and understand the Candidate Information Bulletin.*

    Signature:_____ **Date:**_____