Health Certification Project
REQUEST FOR APPROVED CLINICAL SKILLS OBSERVER
Nurse Aide Certification

Please add the following individual to the list of approved Clinical Skills Observers for the Health Certification Project (HCP):

NAME OF INDIVIDUAL:	
STREET ADDRESS (HOME):	
CITY, STATE, ZIP:	
EMAIL ADDRESS:	☐ CNA Clinical Skills Observer ☐ AUA Clinical Skills Observer*
RN/LPN/MD NUMBER:	**YEARS EXPERIENCE (attach resume):**
DATE OF TRAINING:	**NAME and CSO NUMBER OF CSO WHO OBSERVED INDIVIDUAL:**
HCP TEST SITE CODE:	**NAME OF TECHNOLOGY CENTER:**

I attest that this individual has been trained on state and local HCP testing procedures, has observed proper clinical skills testing procedures and has been observed a CSO listed on the HCP Approved CSO List.

_____ _____

HCP Test Center Coordinator Signature Date

I, the undersigned, understand that all Health Certification Project materials used for certification testing are proprietary and confidential. I understand that maintaining test item security prohibits any test site staff member from the following:

1. unauthorized photocopying any test items or materials,
2. selling or disclosing the content of test materials/test items to any person or organization, public or private,
3. removing test materials from the secure locations without authorization from the test site coordinator,
4. utilizing test items in any form, either from a copy of the test instrument or as a practice exercise to expose candidates to the test items,
5. utilizing ODCTE testing materials to generate another testing instrument for any purpose .

I understand that I am approved to administer clinical skills examinations at the above site and through the HCP Test Center submitting this request. I have been trained on state and local testing procedures for handling and administering clinical skills examinations, read all required manual(s) and agree to follow those protocols.

I further understand that the HCP Test Center Coordinator will have open access to all testing functions and information necessary to verify that HCP tests are being administered in accordance with state and local HCP testing policies and procedures.

_____ _____

Clinical Skills Observer Signature Date

*Only select AUA if you meet the qualifications as noted in the AUA manual, required by OK Board of Nursing:
(Unrestricted RN license; 2 years experience as a staff nurse in an acute care setting.)

Scan this form and the individual's resume and send to the state HCP office in Stillwater via email or sFTP upload. Retain original form and documentation at HCP Test Site.

HCP STATE OFFICE USE ONLY:

CSO Number: _____ Date added to CSO List: _____ Added by (initials): _____