



### TEST SITE DIRECTORY

Test Center: \_\_\_\_\_ Center Number: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
City Zip

Mailing Address: \_\_\_\_\_  
City Zip

I attest that the individuals listed below have been properly trained on the requirements for all licensure/certificaton testing as identified in any applicable state and federal regulations as well as the Health & Professional Certification Project policies and procedures. I further attest that these individuals have been trained on the importance of test security and advised that individuals who compromise test security may be held responsible for the cost of development of new materials.

Test Site Coordinator Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### TEST CENTER STAFF TRAINING ATTESTATION

By my signature below, I verify that I have received training on all licensure/certification requirements, policies and procedures. I further attest that I understand the importance of test security and I may be held responsible for the cost of development of new materials if my actions compromise test security. **NOTE: DO NOT** include Clinical Skills Observers on this directory.

Name	Signature	Telephone	Email Address	Signature Proxy (limit 2)
HCP Coordinator Name	Coordinator Signature	Coord. #	Coordinator E-mail	