Reset Form

QUALIFIED MEDICATION AIDE COMPETENCY EVALUATION APPLICATION

State Form 17213 (R8 / 7-23)
INDIANA DEPARTMENT OF HEALTH – Consumer Services & Health Care Regulation

SECTION 1: APPLICANT INFORMATION

Applicant's LEGAL Name: _____ Sex: ☐ F ☐ M
Last First M.I.

Address *(number and street)*: _____ Telephone number: _____

City, State, ZIP code: _____ County: _____

Date of birth *(month, day, year)*: _____ CNA Registry number: _____ SSN*: _____

E-mail Address: _____

*PRIVACY NOTICE TO APPLICANT: The Indiana Department of Health is requesting disclosure of your Social Security Number (SSN) to accomplish its purpose under IC 4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

SECTION 2: COURSE INFORMATION (60 HOUR CLASSROOM EDUCATION)

Facility/School Name *(no abbreviations)*: _____ Telephone number: _____

Address *(number and street)*: _____ IDOH QMA Training number: _____

City, State, ZIP code: _____ County: _____

Date of Classroom Completion *(month, day, year)*: _____ Program Instructor's PRINTED Name: _____

I verify that the above named applicant has successfully completed at least sixty (60) hours of classroom instruction using IDOH approved training materials and that a summary of all assessment tools and checklists are completed and available in this applicant's file.

Program Instructor's Signature | Program Instructor's License # | Date *(month, day, year)*

SECTION 3: COURSE INFORMATION (40 HOUR PRACTICUM)

Facility Name: _____ Telephone number: _____

Address *(number and street)*: _____ Facility Number: _____

City, State, ZIP code: _____ County: _____

Date of Practicum Completion *(month, day, year)*: _____ Nurse Supervisor's PRINTED Name: _____

I verify that the above named applicant has, under my supervision, successfully completed at least forty (40) hours of practical experience administering medications and performing procedures according to IDOH approved training materials.

Nurse Practicum Supervisor's Signature | Nurse Practicum Supervisor's License # | Date *(month, day, year)*

SECTION 4: APPLICANT VERIFICATION

I verify that all of the above information is correct. I understand that falsification of this document may result in denial or revocation of my qualification.

Applicant's Signature: _____ Date *(month, day, year)*: _____

SECTION 5: CANDIDATE STATUS

☐ **100 HOUR CLASS**
☐ **Psychiatric Attendant**
☐ **Other:** _____

☐ **Out-of-State QMA - State:** _____
☐ **Nursing Student - School:** _____
☐ **Foreign Nurse - Country:** _____

SECTION 6: DOCUMENTATION

The following required documents are included with this request to test:

☐ **Original** Application
☐ **Original** documentation of practicum

☐ Copy of High School Diploma, GED or transcript
☐ Copy of current Indiana Nurse Aide Registry certification

Nursing Students must include: ☐ **Official** transcript from nursing school; ☐ **Original** Application; AND ☐ **Original** documentation of practicum.

Out-of-State medication aides must include: ☐ **Original** Application; ☐ Copy of current Indiana Nurse Aide Registry certification letter; AND ☐ Out-of-state medication aide certification document.

SECTION 7: TEST RESULTS

FIRST TESTING

Test Entity	
Tester	**Test Date** ***(month, day, year)***
Test Site	**County**
WRITTEN TEST RESULTS: ☐ **PASS** ☐ **FAIL**	**SCORE**

SECOND TESTING

Test Entity	
Tester	**Test Date** ***(month, day, year)***
Test Site	**County**
WRITTEN TEST RESULTS: ☐ **PASS** ☐ **FAIL**	**SCORE**

THIRD TESTING

Test Entity	
Tester	**Test Date** ***(month, day, year)***
Test Site	**County**
WRITTEN TEST RESULTS: ☐ **PASS** ☐ **FAIL**	**SCORE**