TRAINING VERIFICATION FORM

Certified Medication Aide

Oklahoma State Department of Health
Nurse Aide Registry
PO Box 268816
Oklahoma City, OK 73126-8816
Ph. 405-426-8150

CANDIDATE INFORMATION

Name _____ Social Security Number _____

TRAINING INFORMATION

Training Facility Name: _____

Training Facility Address: _____

Training Completion Date: _____ Training Facility Code: _____

_____ _____
Instructor's Name (Please print clearly) Instructor's Signature

TRAINING VERIFICATION STATEMENT

I verify that the above named candidate has successfully completed the minimum number of training hours and that this training was provided through a program approved by the Oklahoma State Department of Health. I also attest that, after training was completed, the above named candidate passed medications to 20 consecutive individuals without error and that documentation of these medication passes has been retained in his/her training file.

RN LPN Other

_____ _____
Training Supervisor's Name (Please print clearly) Training Supervisor's Signature

_____ _____
Training Supervisor's Telephone Number Date

CERTIFIED MEDICATION AIDE STATEMENT OF ATTESTATION

I, _____ , attest that I meet all of the following requirements for certification as a medication aide (please initial each in the blank provided):

_____ I am at least eighteen years of age.

_____ I have high school diploma or G.E.D.

_____ I have a current Oklahoma nurse aide certification with no abuse notations.

_____ I have at least six months experience working as a certified nurse aide.

_____ I have the physical and mental capability to perform the duties of a CMA.

_____ I passed medications to 20 consecutive individuals without error after completing the training program above.

_____ _____
Candidate Signature Date of Signature

_____
Candidate Name (printed)

WRITTEN COMPETENCY EXAMINATION RECORD

The Test Site Coordinator must sign and date this form at each written competency test administration. **Candidates that do not pass the written competency examination after three attempts must retrain and repeat the testing process.**

Written Exam 1 _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Written Exam 2 _____ Date _____ Pass/Fail
Test Site Coordinator Signature

Written Exam 3 _____ Date _____ Pass/Fail
Test Site Coordinator Signature