OKLAHOMA State Department of Health

Nurse Aide Registry (NAR)
PO Box 268816
Oklahoma City, OK 73126-8816
Tel. (405) 426-8150

Certified Medication Aide Retest Application OAC 310:677-1-3(g)

Section 1 – Certified Medication Aide Retest

*If your CMA certification has been expired for more than one (1) year you must retest. If you have been expired for three (3) years or longer you must retrain.**

CMA Retest - $15 Fee Required Original Expiration Date:_____

Reason for Retesting

☐Expired over one (1) year, but no more than three (3) years.

☐Did not take Continuing Education Update class before expiration or within one (1) year of expiration (OAC 310:677(b)(4)

You are a nurse aide currently certified in (please select ALL appropriate certification(s)):

☐**LTC – Expiration Date:_____** ☐**HHA – Expiration Date:_____** ☐**DDCA – Expiration Date:_____**

Section 2 - Personal Information

___/___/___ Date of Birth _____/_____/_____ Social Security Number

_____

First **MI** **Last**

If you have had a **name change since your last renewal, please include a certified copy of the marriage license or other court document which reflects the change of name when you submit this application.**

_____

Current Mailing Address **City** **State** **Zip**

_____ _____

E-mail address **Telephone Number**

If this application is approved, you will receive an approval letter to take the written and skills exams at the testing facility of your choice. The original letter MUST be presented to the testing site before you will be authorized to take the examinations. Duplicate retest approval letter will not be reissued.

Upon completion of your test the testing entity has 30 days to submit testing results to the Nurse Aide Registry, at which time you will be added to the database. You may verify your certification status online at nar.health.ok.gov

If you have any questions, please call our office at **(405) 426-8150** or by email at nar@health.ok.gov .

Section 3 - Attestation for CMA Retest

Please verify that the information provided is correct. The Oklahoma State Department of Health may deny, suspend, withdraw &/OR not renew the certification of a medication aide who intentionally provides false or misleading information to a training program, a facility or the Oklahoma State Department of Health.

☐ Yes ☐ No I am a minimum of 18 years of age.
☐ Yes ☐ No I have a minimum education of high school or general equivalency diploma.
☐ Yes ☐ No I have a current Oklahoma LTC, HHA &/OR DDCA nurse aide certification with no substantiated abuse notations.
☐ Yes ☐ No I have the physical and mental capability to safely perform the duties of a nurse aide.

Section 4 – Affirmation

I affirm the information on this form to be true and correct to the best of my knowledge.

X_____ ___/___/___ _____

Signature of Nurse Aide **Date** **Name of most recent Facility/Agency where employed – Phone**

Make check/money order payable to: **OSDH/Nurse Aide Registry**
Mail to: **NAR-OSDH, PO Box 268816, Oklahoma City, OK 73102**

NOTE: *All fees submitted are NON Refundable **Total Enclosed $_____**