OKLAHOMA State Department of Health

Oklahoma State Department of Health
Nurse Aide Registry
PO Box 268816
Oklahoma City, OK 73126-8816
Ph. 405-426-8150
Fax: 405-900-7572

Application for Certified Medication Nurse Aide Training Competency and Evaluation Program

Check the type of training program you will be providing.

☐ Employer Based
☐ Education Based – ☐ Adult Career Development ☐ RN Program ☐ LPN Program
☐ Private _____

Complete the following and return to the above address
Please type or print information

Organization/Agency Name: _____

Training Location Address: _____

Mailing Address: _____

Telephone Number: _____ Fax Number: _____

Contact Person/Title: _____

E-mail Address: _____

There is a $100 application fee for a Certified Medication Nurse Aide Competency and Evaluation Training program as specified in OAC 310:677-3-2(b).

SECTION I. Records

Attachment # 1
Complete the method used for retaining the required records for at least three (3) years as specified in **OAC 310:677-3-8(d)** and the location of the administrative office of the program and the location where records are being maintained as in **OAC 310:677-3-3(c)(2).**

Attachment # 2
The following information required to be given to trainees.

The program provides current written information to applicants about:

1. Policies for admission and satisfactory completion of the program.
2. Purpose and objectives of the program with class syllabus.
3. Trainee rights and responsibilities.
4. Successful completion of a nurse aide training and competency evaluation program results in the individual being listed in the OSDH's nurse aide registry. **OAC 310:677-3-11(d)**
5. State law requiring employers to secure an Oklahoma State Bureau of Investigation criminal arrest report. **OAC 310:677-7**

6. Requirements for renewal of the registry listing. **OAC 310:677-13-8. Certification and recertification**

Trainees

The trainee shall be appropriately identified as a trainee whenever the individual is performing the required clinical skills training.

Describe how the trainee will be identified as a certified medication nurse aide trainee:_____

Attachment # 3
Complete program's procedures for communication and distribution of the "Affidavit of Lawful Presence".

Oklahoma Taxpayer and Citizen Protection Act of 2007:
The Oklahoma Legislature passed a new immigration law (**HB1804)** that went in to effect November 1, 2007. The law requires an affidavit of legal residence from anyone seeking to receive certain qualifying services or a license, permit, or **certification** from the Department. This law is called the Oklahoma Taxpayer and Citizen Protection Act of 2007.

The affidavit must be completed and signed by the trainee or guardian and the original presented to the written testing site prior to testing. A signed affidavit is required for entry on the Nurse Aide Registry. Submit the training program's procedure to ensure the requirements for submitting the "Affidavit of Lawful Presence by Person" are communicated to trainees eligible for testing and certification and how the form is distributed

Attachment # 4
If Education Based Program or Other Program, complete an itemized list of charges made to trainees.

SECTION II. Staff Names and Qualifications:

Attachment # 5
Complete the attached Instructor Qualifications Application as specified in **OAC 310:677-13-3.**

Attachment # 6
Complete program's requirement of education and experience for supervisors and instructors and procedure to ensure requirements are met as in **OAC 310:677-3-3(c)(7).**

SECTION III. Classroom and Clinical Facilities:

Attachment # 7
Complete the attached Name and Location of Classroom and Clinical Facilities as specified in **OAC 310:677-3(b)(2).**

Attachment # 8
Complete a description of the program's standards for classroom and skills training facilities including, but not limited to, as in **OAC 310:677-3(b)(4)**.

SECTION IV. Program outline, with objectives, curriculum and instruction methods

Attachment # 9

Complete a program outline, with objectives, curriculum and instruction methods as specified in **OAC 310:677-13-4**.

Provide a lesson plan/syllabus (topics/training for day 1, day 2, day 3, etc. with breakdown of hours for each day)

(A model of the Certified Medication Nurse Aide Training Curriculum is attached. If there are additions in curriculum beyond the required training, please add to the attachment. This model is provided as a courtesy by OSDH and is not a required form.)

Skills Performance Checklist – Attachment #10

A Certified Medication Aide training program shall use a performance check list as specified in **OAC 310:677-3-8(a)(1-2)**. Attached is an approved model Performance Skills Checklist which can be used by the training program.

Upon request from the nurse aide trainee, the training program shall provide the trainee a copy of the completed Skills Performance Checklist with the skills that have been demonstrated if the trainee has to withdraw from the training program prior to completion of the training program as required in **OAC 310:677-3-8(a)(2)(c)**.

This form must be kept in the trainee's records for at least three (3) years as in **OAC 310:677-3-8(a)(2)(d).**

(A model of Skills Performance Check list is attached. This model is provided as a courtesy by OSDH and is not a required form.)

I certify that the foregoing is true and complete to the best of my knowledge.

_____

Type or Print Name of Authorized Individual Signing for Program

_____ _____

Signature Date

Attachment #1

Retaining of Required Records

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete the method used for retaining the required records for at least three (3) years as specified in:
OAC 310:677-3-8(d)

(1) The trainee's Application for the training program.
(2) Performance records, the Skills Performance Checklist and Training Verification Form.
(3) Nurse aide competency and examination results,

and the location of the administrative office of the program and the location where records are being maintained as in **3:677-3-3(c)(2).**

Attachment #2

Information to be given to Trainees as Required by Regulation and Law

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete and attach a copy of the information required as specified below that will be given to the trainees.

The program provides current written information to applicants about:

1. Policies for admission and satisfactory completion of the program.
2. Purpose and objectives of the program.
3. Trainee rights and responsibilities.
4. Successful completion of a nurse aide training and competency evaluation program results in the individual being listed in the OSDH's nurse aide registry. 310:677-3-11(d)
5. State law requiring employers to secure an Oklahoma State Bureau of Investigation criminal arrest report. 310:677-7
6. Requirements for renewal of the registry listing. 310:677-5-2(d)(e), 9-1(c)

(A model of the required information to be given to trainees is attached. This model is provided as a courtesy by OSDH and is not a required form.)

Attachment #3

Procedures for communication and distribution of the "Affidavit of Lawful Presence"

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete program's procedures for communication and distribution of the "Affidavit of Lawful Presence".

Oklahoma Taxpayer and Citizen Protection Act of 2007:

The Oklahoma Legislature passed a new immigration law (HB1804) that went in to effect November 1, 2007. The law requires an affidavit of legal residence from anyone seeking to receive certain qualifying services or a license, permit, or certification from the Department. This law is called the Oklahoma Taxpayer and Citizen Protection Act of 2007.

The affidavit must be completed and signed by the trainee or guardian and the original presented to the written testing site prior to testing. A signed affidavit is required for entry on the Nurse Aide Registry. Submit the training program's procedure to ensure the requirements for submitting the "Affidavit of Lawful Presence by Person" are communicated to trainees eligible for testing and certification and how the form is distributed

Attachment #4

List of Itemized Charges

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

If Education Based Program or Other Program, complete an itemized list of charges made to trainees.

Attachment # 5

Staff Names and Qualifications

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

OAC 310:677-13-3

(a) Each training program instructor shall be qualified as a physician, licensed nurse, pharmacist, respiratory therapist, speech therapist, or certified diabetes educator who may teach within her or his area of expertise or scope of practice. Each instructor shall have one (1) year of experience in her or his area of expertise. **The program shall designate a registered nurse as the training program supervisor if a licensed practical nurse serves as an instructor.**

(b) Other personnel from the health professions may supplement the instructor as required by the curriculum and approved by the Department.

RN Supervisor _____ License #_____

Experience:

I _____ have number of years' experience in field of expertise _____

B. Submit a short biographical sketch:

InstructorsName _____ License #_____

Experience:

I _____ have number of years' experience in field of expertise _____

B. Submit a short biographical sketch:

InstructorsName _____ License #_____

Experience:

1. _____ have number of years' experience in field of expertise _____

B. Submit a short biographical sketch:

Attachment #6

Procedure Ensuring Education and Experience of Supervisors and Instructors

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete and attach policy for program's requirement to ensure position descriptions and education and experience requirements for training supervisors and instructors, and the program's procedure for ensuring that supervisors and instructors satisfy such descriptions and requirements are met as in OAC 310:677-3-3(c)(7).

Attachment #7

Classroom and Clinical Facilities

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Clinical Skills Evaluation:

The clinical skills demonstration shall be:

(1) performed in a comparable to the setting in which the individual will function as a nurse aide; and

(2) administered and evaluated by a registered nurse with at least one (1) year experience in providing care for the elderly or chronically ill of any age. Attach a copy of the certificate of completion of the clinical skills training.

Clinical Skills Observers:_____

Complete the attached Name and Location of Classroom and Clinical Facilities as specified in OAC 310:677-3(b)(2).

Written Exam:
Location:_____

Clinical Exam:
Location:_____

Clinical Facilities:

Facility:_____
Address:_____
Name of Contact at Facility:_____
Phone #:_____

Facility:_____
Address:_____
Name of Contact at Facility:_____
Phone #:_____

Attachment #8

Standards for Classrooms

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete a description of the program's standards for classroom and skills training facilities including, but not limited to, as in OAC 310:677-3(b)(4).

Heating Cooling				
Clean, safe conditions Floor clean, uncluttered Electrical outlets available & working Wastebaskets Clock Available Environmental hazards (identify & list on separate page)				
Space Adequate number of chairs Adequate number of desks Adequate space for trainees, equipment & materials.				
Lighting Direct lighting Suitable for tasks to be performed Indirect lighting Minimal glare				
Equipment & Training Materials IVD system in working order, if needed Overhead projector, if needed Reference books and materials Supplies				
Clinical Skills Lab Clinical skills lab provides space for equipment and trainees Mannequin, if needed Basic skills supplies, i.e., bath basin, personal care items, blood pressure equipment, patient beds, among others Handwashing facility easily accessible				

Attachment #9

Program Outline and Curriculum

Training Program Name:_____

Training Location Address: _____

Contact Person _____Telephone #(___)_____

Complete and attach the model of Certified Medication Aide Training Curriculum. If there are additions in curriculum beyond the required training, please add to the attachment. This model is provided as a courtesy by OSDH and is not a required form.