

Health Certification Project

TRAINING VERIFICATION FORM – Certified Medication Aide

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 _____
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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		