



NURSE AIDE REGISTRY
OKLAHOMA STATE DEPARTMENT OF HEALTH
Application for Advanced Training Certificate
Certified Medication Aide

Nasogastric/Gastrostomy/Oral Metered Dose Inhaler/Nebulizer

Submit this form with the \$10 (check or money order) non-refundable fee to:

Nurse Aide Registry-OSDH • P.O. BOX 268816 • Oklahoma City, OK 73126-8816

TRAINEE INFORMATION

Name: _____ **Social Security Number:** _____

Address: _____

City, State & Zip: _____ **Phone: Area Code ()** _____

I completed the CMA Advanced Training Program indicated on this application and request issuance of an advanced training certificate.

Signature of Trainee _____ **Date** _____ **E-mail Address** _____

TRAINING INFORMATION

Please check (√) the training program completed and indicate the number of training hours completed per 310:677-13-4(d). Only to be signed after training is complete.

☐	Training on administration of medications and nutrition via nasogastric and gastrostomy tubes and Training on administration of oral metered dose inhalers and nebulizers. (A combined minimum of 8 hours of classroom and supervised practical training.)
Total Hours	

Training Program Code: _____ **Training Program Name:** _____

Training Program Address: _____

Training Instructors Name: _____ **Instructor signature:** _____

TRAINING VERIFICATION STATEMENT

I verify that the above named CMA trainee has completed the training program indicated on this form on the date identified and that the training program has been **approved by the Oklahoma State Nurse Aide Registry.**

Date Trainee Started Training: ____/____/____ **Completed Training:** ____/____/____

RN Training Instructor/Supervisor's Signature

RN's License Number & Expiration

Area Code ()

RN Training Instructor/Supervisor's Telephone Number
