

**Nurse Aide Certification Deeming Table
Chapter 677. Nurse Aide Training and Certification**

I want to be a →	CMA ¹	HHCA	LTCA	CMA	ICE/IID	RCA	ADCA
I am a: HHCA ² Minimum 75 hours training	40 Hours Training in Required Topics		16 hours Training in Required Topics	Train and Test	16 hours Training Specific to Population	16 hours Training Specific to Population	16 hours Training Specific to Population
I am a: LTCA ¹ Minimum 75 hours training		16 hours of Orientation Training Specific to Population and a Skills Test		Train and Test	16 hours Training Specific to Population	16 hours Training Specific to Population	16 hours Training Specific to Population
I am a: ICE/IID Minimum 75 hours training		Train and Test	Train and Test	Train and Test		16 hours Training Specific to Population	16 hours Training Specific to Population
I am a: RCA Minimum 45 hours training		Train and Test	Train and Test		Train and Test		16 hours Training Specific to Population
I am a: ADCA Minimum 45 hours training		Train and Test	Train and Test		Train and Test	16 hours Training Specific to Population	

HHCA – Home Health Care Aide (Minimum 75 hours training)

LTCA – Long Term Care Aide (Minimum 75 hours training)

CMA – Certified Medication Aide - (Minimum 40 hours training)

ICE/IID –Intermediate Care Facility for Individuals with Intellectual Disabilities Aide - (Minimum 75 hours training)

RCA – Residential Care Aide - (Minimum 45 hours training)

ADCA – Adult Day Care Aide - (Minimum 45 hours training) (Dec 2008)

"Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual.

¹ Certified Medication Aide: Prior to issuance of certification a minimum of 40 hours training is required which includes sixteen (16) hours of supervised practical training followed by written and skills examinations.

² Prior to issuance of certification a minimum of 75 hours training is required which includes sixteen (16) hours of supervised practical training followed by written and skills examinations.



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

Long Term Care Aide
Deemed to Home Health Aide Application

(This application is to be used by a Long Term Care Aide to document 16 hours of training specific to the home health population to become certified as a Home Health Aide.)

Cost: \$15.00 Nonrefundable Processing Fee

Nurse Aide Name: _____

Home Address: _____

Social Security Number: _____

LTC Certification Number: _____ **Date of Hire:** _____

Topic	Date	Time Spent	Instructors Initials

Instructor Signature: _____ **Date:** _____

Facility or Technology Center Where Trained: _____

Nurse Aide E-Mail: _____

Nurse Aide Signature: _____ **Date:** _____



TRAINING VERIFICATION FORM

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

TRAINEE INFORMATION

Trainee Name: _____ Social Security #: ____ - ____ - ____

TRAINING INFORMATION

Please check (✓) the training program the trainee completed and indicate the number of training hours completed.

☐ _____ Long Term Care Hours (75 Hr. Minimum)	☐ _____ Deeming _____ to _____ Hours 16 Hr. Minimum)	☐ _____ Adult Day Care Hours (45 Hr. Minimum)
☐ _____ Home Health Aide Hours (75 Hr. Minimum)	☐ _____ Developmentally Disabled Direct Care Hours (75 Hr. Minimum)	☐ _____ Residential Care Hours (45 Hr. Minimum)

Date Examinee completed the training program: _____ Training Facility Code: _____

Training Program/Facility Name: _____

Training Program/Facility Address: _____

Instructor's Name (Please print clearly)

Instructor's Signature

TRAINING VERIFICATION STATEMENT

I verify that the above named trainee has successfully completed the minimum number of training hours and all required performance checklists for program indicated above. Furthermore, this training was provided through a program approved by the Oklahoma State Department of Health within the last 24 months. (NOTE for Long-Term Care Aide and Home Care Aide Training Programs: This form must be signed by the R.N. who is listed on the NATCEP application as the R.N. Training Supervisor. LPNs cannot be Training Supervisors for LTC and HHC training programs and may not sign this form.

Training Supervisor's Name (Please print clearly)

Training Supervisor's Signature

Area Code () _____

Training Supervisor's Telephone Number

Date

CLINICAL EXAMINATION RECORD

The assigned RN/CSO must sign and date this form after scoring each skill in the clinical skills exam. **Trainees that do not pass the clinical examinations after three attempts must retrain and repeat the testing process.**

Exam 1: RN/CSO _____	_____	_____	☐ Pass	☐ Fail
Printed Name	RN/CSO Signature	Date		
Exam 1: RN/CSO _____	_____	_____	☐ Pass	☐ Fail
Printed Name	RN/CSO Signature	Date		
Exam 1: RN/CSO _____	_____	_____	☐ Pass	☐ Fail
Printed Name	RN/CSO Signature	Date		

WRITTEN COMPETENCY EXAMINATION RECORD

The assigned Testing Proctor must sign and date this form at each written competency test administration. **Trainees that do not pass the written competency examination after three attempts must retrain and repeat the testing process.**

Written Exam 1 _____	_____	☐ Pass	☐ Fail
Assigned Testing Proctor	Date		
Written Exam 1 _____	_____	☐ Pass	☐ Fail
Assigned Testing Proctor	Date		
Written Exam 1 _____	_____	☐ Pass	☐ Fail
Assigned Testing Proctor			

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 _____

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 refrain 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



Application for Advanced Training Certificate

Certified Medication Aide – Diabetes Care

Glucose Monitoring/Insulin Administration

Nurse Aide Registry

P. O. Box 268816

Oklahoma City, OK 73126-8816

Phone (405) 428-8150

TRAINEE INFORMATION

Trainee Name (Printed): _____ Social Security #: _____

Address: _____

City, State & Zip: _____ Phone: (____) _____

I completed the CMA Advanced Training Program for Diabetes Care. I request to have this additional training noted on the Oklahoma Nurse Aide Registry.

Trainee Signature/ E-mail: _____ Date: _____

TRAINING INFORMATION

NOTE: CMA's are eligible to perform only the task of Blood Glucose Monitoring after completion of the 6 hour classroom program and 2 hours of supervised practical training.

Please enter the number of training hours completed.

_____ Training on care of diabetes – Glucose Monitoring Hours

A minimum of six hours of classroom training and two hours of supervised practical training

_____ Training on care of diabetes – Glucose Monitoring and Insulin Administration Hours

A minimum of twelve hours of classroom training and a minimum of four hours of supervised practical training.

Training Instructor's Name/Signature: _____ Phone #: (____) _____

Training Program Code: _____ Training Program Name: _____

Training Program Address: _____

INFORMAL TESTING AND SKILL PROFICIENCY RECORD

Skill proficiency of 100% accuracy -Date: _____ Administered by: _____

Written test of 90% accuracy – Date: _____ Administered by: _____

TRAINING VERIFICATION STATEMENT

I verify that the above named CMA Trainee has completed the GM/IA training program indicated on this form on the date identified and that the training program has been approved by the Oklahoma State Dept. of Health. I have also verified that the above named CMA Trainee has satisfied the state requirements for skills proficiency and written tests administered during training.

Date Trainee Started Training: _____ Completed Training: _____

RN Supervisor Name/E-mail: _____ Date: _____

Supervisor Signature: _____ Phone #: (____) _____

WRITTEN CERTIFICATION EXAMINATION RECORD – INSULIN ADMINISTRATION

Exam Date:	Test Proctored By:	Candidate Scored 80% or higher?
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N

CHECK APPLICABLE BOX:

_____ Trainee PASSED Insulin Administration written certification exam and has demonstrated competency for both insulin administration and glucose monitoring.

_____ Trainee FAILED Insulin Administration written certification exam and has only demonstrated competency for glucose monitoring.

In order to be listed on the Oklahoma Nurse Aide Registry and receive a certification card, the Trainee must submit this completed form with a \$10 non-refundable certification fee to the mailing address above.



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 with 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

RN Training Instructor/Supervisor's Telephone Number with Area Code
