FOR OFFICE USE ONLY

Date Received

Receipt #

ID #

Issue Date

License #

Rhode Island
Nursing Assistant Advisory Board

Room 104
3 Capitol Hill
Providence, RI 02908-5097

OFFICE USE ONLY

Instructions and Application For
License As A Medication Aide

By Certification

☐ NA license #_____

Expiration Date_____

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	***FIRST NAME***	***MI***

DO NOT REMOVE THIS PAGE FROM APPLICATION

Phone: (401) 222-5888 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-6683**

Revised 01/03/2018 jcp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Licensure Requirements

All Applicants

- Recent passport type photograph (no photocopies).
- A Full Bureau of Criminal Investigation (BCI) Check (see application checklist - page 5).
- An original of certifiied copy of your birth certificate/proof of age.
- A copy of your high school diploma or your high school diploma/GED.
- Processing Fee: **$35.00** Paid by Applicant (covers application processing and intial license).
- 3 Completed and signed Medication Aide Technique Evaluation Checklists - (pages 10, 11, 12)

Military Expedited

If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Rules and Regulations/Laws

To obtain the Rules and Regulations for your profession visit the following web site. From the list click on the your profession.

http://www.health.ri.gov/licenses/

Chapter 23, Title 17.9 entitled “Registration of Nursing Assistants” can be downloaded at the following web site:

http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm

Initial License

Once your completed application has been reviewed and approved, you will be issued your initial license. Please note: that license may expire within a few months up to two years after your examination. Expiration dates are randomly assigned. Depending upon your expiration date, you may need to renew your license prior to the normal two-year expiration period.

Renewals

A renewal notice will be mailed to you approximately sixty (60) days prior to the license expiration date. You must obtain the signature of an official in a **licensed health care facility** (i.e. nursing home) where you were employed as a Medication Aide within the 24 months prior to renewal. **If you document that you were working in a facility other than a licensed health care facility, you will not be eligible for renewal. YOUR REGISTRATION MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER.**

APPLICATION PROCESS OVERVIEW

Continuing Education Credits

Beginning 1 July 2010, licensees at the time of renewal, will need to verify a minimum of four (4) hours of continuing education credits in the previous two (2) years.

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Nursing Assistant Advisory Board (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 5) must be submitted for an application to be considered complete. **"APPLICATIONS ARE VALID FOR A ONE (1) YEAR PERIOD".**

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have a malpractice, criminal or disciplinary history in Rhode Island, or another state, it can take an additional 2 or 3 months for processing your application.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. Visit the following website to obtain a change of address form.

http://www.health.ri.gov/forms/changeofaddress/professions.pdf

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

https://healthri.mylicense.com/Verification/

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5888.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark “N/A” for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application pages (6-9). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **$35.00** payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is NONREFUNDABLE.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 5). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

Rhode Island Department of Health
Nursing Assistant Advisory Board
Room 104, 3 Capitol Hill
Providence, RI 02908-5097

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the application as instructed (pages 6-9).
- ☐ I have had my training program complete Section 8.
- ☐ I have had my employing facility complete Section 9.
- ☐ I have completed Section 12, **"Affidavit of Applicant"**, and have had the affidavit section completed and notarized by a notary public.
- ☐ I have attached a photograph to Section 13, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have attached a copy of my high school diploma/GED.
- ☐ I have attached proof of my age (i.e. birth certificate/driver's license).
- ☐ I have attached a copy of the certifcate of completion of my mediation aide program.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the amount of **$35.00** and attached it to the upper left-hand corner of the first (Top) page of the application (All fees are NON-REFUNDABLE).
- ☐ I have attached three (3) completed and signed Medication Aide Technique Evaluation Checklists (pages 10, 11, 12) These checklists must be from three (3) different dates
- ☐ I have arranged my Board Application materials in the following order.
    1. Fee (attached as instructed).
    2. Board Application (**including cover page**) (pages 6-9).
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
- ☐ I have mailed the above application materials directly to the Rhode Island Nursing Assistant Advisory Board.

Additional Requirement for ALL CANDIDATES

I have requested a full Bureau of Criminal Investigation check (BCI) from the Attorney General's Office, 150 South Main Street, Providence, RI 02903 - (401) 274-4400 as instructed. **If you answer yes to question 10 on page 7, and you do not provide a complete explanation describing your criminal activity, your application will not be processed. If you do not compete the application process within six (6) months from the date of the BCI, a current BCI will need to be submitted before you will be licensed.**

State of Rhode Island
Nursing Assistant Advisory Board
Application for License as a Medication Aide

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year 19

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Training Information

Date of Completion of Qualifying Clinical Training: Month ____ Day ____ Year ____

License Number of Training Program: M A T ____

Signature Required

Please verify the information about the training that qualifies this applicant for a license.

Signature _____ Title _____ Date _____

Print or Type Name _____ Phone ___ ___ – ____

9. Medication Administration Competency

Date of Completion of Medication Administration: Month ____ Day ____ Year ____

Signature Required

Please verify that the applicant has demonstrated proficiency with the administration of medication.

Signature _____ Title _____ Date _____

Print or Type Name _____ Phone ___ ___ – ____

10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? **If you answer yes and you do not provide an explanation, your application will not be processed. If you do not pass both examinations with six (6) months from the date of the BCI, a current one will need to be submitted.** ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance): Month Year

_____ ____ ____

If you answer yes, you must give complete

_____ ____ ____

_____ ____ ____

details as to what led to the arrest(s).

11. Disciplinary Questions

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details on the next page, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. If you answer "Yes" to any question you **must** attach originals, or certified copies of any court documentation to this application.

11. Disciplinary Questions explaination page:

12. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Medication Aide in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Nursing Assistant Advisory Board of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant | Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____

Name of Notary (Print, Type or Stamp) | Signature of Notary

Notary Seal

_____ _____

Notary No/Commission No. | Commission Expiration Date (MM/DD/YY)

13. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

NO PHOTOCOPIES

ATTACH WITH CLEAR TAPE ONLY

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____

Date of Photograph

You are required to have three (3) checklists completed
Checklists must be from three (3) different dates.
You must use this form; no other forms will be accepted.

Medication Aide Technique Evaluation Checklist

MEDICATION(s)	Yes	No	Remarks
1. Understands the order as written on medication sheet and med card.			
2. Brings med sheet or card to med room, closet or cart.			
3. Washes hands.			
4. Identifies medication container with med sheet or card.			
5. Removes medication from shelf or cart.			
6. Compares medication label with med sheet or card.			
7. Determines dosage and proper amount of medication to pour.			
8. Pours without touching medication.			
9. Keeps poured medication and med sheet or card together.			
10. Returns medication to shelf or cart.			

LIQUID MEDICATION(s)

11. Proceeds as for oral medication Items #1 - 8 above.			
12. Holds medication with label turned toward palm of hand.			
13. Holds med cup with liquid at eye level to measure.			
14. Wipes bottle before returning to shelf or cart.			
15. Locks medication room, closet or cart when done.			

INPATIENT AREAS

16. Identifies patient thoroughly.			
17. Offers medication and water.			
18. Remains with patient until medication is swallowed.			
19. Charts correctly.			

GENERAL COMMENTS:

SIGNATURES:

Date Completed: _____

RN Name:_____ **RN License Number:**_____

RI Licensed Facility Name:_____

RI Licensed Facility License Number:_____

Medication Aide Name: _____

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_____

SIGNATURES:

Date Completed: _____

RN Name:_____**RN License Number:**_____

RI Licensed Facility Name:_____

RI Licensed Facility License Number:_____

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_____

_____

_____

SIGNATURES:

Date Completed: _____

RN Name:_____**RN License Number:**_____

RI Licensed Facility Name:_____

RI Licensed Facility License Number:_____

Medication Aide Name: _____