FOR OFFICE USE ONLY

Medication Aide Checklist

- ☐ Application
- ☐ Application Fee
- ☐ Valid ID
- ☐ Copy of HS Diploma/GED
- ☐ Transcript/Certification MAD Program
- ☐ 3 Medication Evaluation Forms
- ☐ BCI

FOR OFFICE USE ONLY

Date Received

Receipt #

ID #

Issue Date

License #

STATE OF RHODE ISLAND HOPE

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

LICENSURE REQUIREMENTS

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.
- ☐ 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 to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE; and
- ☐ Copy of Driver's License or State Issued ID
- ☐ Copy of high school diploma or GED
- ☐ Original Transcript or Certification of Completion of a Medication Aide Training Program
- ☐ 3 Completed and signed Medication Aide Technique Evaluation Checklists (enclosed in this application). Must be completed by the Nurse that is doing the evaluation.
- ☐ **Original** BCI (Background Check) with stamp and seal from the RI Attorney General's Office **only**. For information on this process please visit their website at **http://www.riag.ri.gov/BCI**. If positive BCI, a detailed explanation is required. BCI must be dated within 4 months of the date of this application.
- ☐ 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.

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others.

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

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:

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 of the Nurse doing the evaluation is Required

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

Signature of Nurse Evaluator | 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

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, including date, place, reason and disposition of the matter. Please attach explanation 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.

12. Affidavit of Applicant

Complete this section and sign.

Make sure that you 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)

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:

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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:____

Medication Aide Name: ____

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SIGNATURES:

Date Completed: ______________________

RN Name:____________________________________**RN License Number:**________________________

RI Licensed Facility Name:____

RI Licensed Facility License Number:____

Medication Aide Name: ____