Coastal Bend College

Beeville Alice Kingsville Pleasanton

NURA 1013 Medication Administration I Checklist

Please do not send in incomplete packets. Utilize this checklist to insure that all forms are turned into the Allied Health Department. Failure to turn in a complete packet on time may result in being removed from the class.

Name:_____

Course Start Date: _____

_____ This checklist

_____ Notarized General Statement Form (to be completed by employer)

_____ Notarized Experience Documentation Report Form (to be completed by employer)

_____Diploma/GED attached to a Notarized Affidavit to any Fact form

_____ Medication Aide Clinical Information form

_____ Criminal Background Check from- www.txdps.state.tx.us

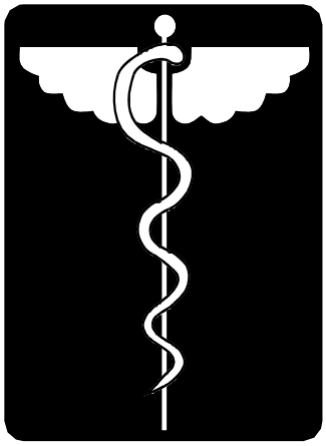
_____ Copy of Certified Nurse Aide Card

_____ $25.00 Money Order for State Licensing

_____ Course fees $ 465.40 (this price does not include books)

_____ Required textbooks are available at the CBC Bookstore:

- Administering Medications 8th Edition, by Gauwitz, ISBN 978-0-07-351375-1;
- DELMAR Nurse's Drug Handbook 2013 published by Cengage, ISBN 978-1-13-32802-8-6



Medication Administration I

The Medication Administration I course will be held at Coastal Bend College. Those who satisfactorily complete the course will receive 14.0CEU's and a certificate of completion from Coastal Bend College. Those who complete the course must pass the Texas Department of Human Services exam with a 70% or higher to become state certified.

The class requires the 140 hours in the following sequence:
100 hours of classroom instruction and training, 20 hours of return skill demonstration laboratory, 10 clinical experience including clinical observation and skill demonstration under the supervision of a licensed nurse in a facility and 10 more hours in the return skill demonstration laboratory.

PERSONS WISHING TO TAKE THE CLASS MUST MEET THE FOLLOWING CRITERIA:

1. Before the class start date, all applicants must be 18 years of age and provide a "Notarized" High school diploma or General equivalency Diploma (GED). Applicants who attended school out of country need to have their documentation evaluated as being equivalent to high school graduation here, and provide an official "notarized" copy.

2. Applicants must be employed as Certified Nurse Aides listed on the Texas Nurse Aide Registry in active status (to check to see if you are on the Nurse Aide Registry call 1-800-452-3934) and currently employed in a facility (see 2a for a definition of "facility") licensed under Texas Health and Safety Code Chapter 242 on the class start date **OR** be employed on class start date as non-licensed direct care staff (see 2b for a definition of a "non-licensed direct care staff person") in a facility licensed under Chapter 247 or an ICF-MR facility, State School for the Mentally Retarded or for the Texas Department of Criminal Justice AND have 90 days previous employment in the year preceding class start date. This does not include home health agencies, hospitals, skilled nursing facilities (SNF) in hospitals or staffing agencies. (An applicant employed as a certified nurse aide in a Medicare – skilled nursing facility or Medicaid nursing facility is exempt from the 90-day requirement.)

    a. Facility – An institution licensed under the Health and Safety Code, Chapter 242; a state school as defined in the Texas Civil Statutes, Article 5544-201, §1.02(16); a correctional institution as established under the jurisdiction of the Texas Department of Criminal

Justice; a mental health and mental retardation program that is operated under the jurisdiction of the Texas Department of Mental Health and Mental Retardation (TDMHMR) and that meets the criteria in §95.103(b) of this title (relating to Requirements for Administering Medications); and a personal care facility licensed under the Health and Safety Code, Chapter 247, that meets the criteria in §95.103(b) of this title (relating to Requirements for Administration Medication).

b. Non-licensed direct care staff – Employees of facilities other than Medicare-skilled nursing facilities or Medicaid nursing facilities who are primarily involved in the delivery of services to assist with residents' activities of daily living and/or active treatment programs.

"For clarification on requirement #2, please call 512-231-5827."

5. Applicants must be free of contagious disease.
6. Students should come to class prepared as you would be for work

TO REGISTER FOR THE MEDICATION ADMINISTRATION I COURSE CONTACT:
CBC's Allied Health Department in Beeville:

Allied Health Support Specialist: Cora Sain
Office: 361-354-2732
E-mail: csain@coastalbend.edu

Or

Allied Health Coordinator: Susie Gaitan
Office: 361-354-2549
E-Mail: mgaitan@coastalbend.edu

Course registration is on a first-come, first-served basis. To avoid cancellations, enrollment forms completed and in the Allied Health office at least five days before the course start date. Payment is accepted by the CBC Business Office by cash, check, money order, Visa or MasterCard. Classes that do not meet the minimum number of students will be cancelled.
Students who have registered and paid are responsible for confirming course start date and times 24 hours in advance of start date.

Medication Aide Clinical Information Form

In order to do your clinicals, we must confirm that you are employed in a long-term care facility. This **Medication Aide Clinical Information Form, must be completed by** your employer. **Once completed, Please return the Medication Aide Clinical Information Form with your completed Student Information Packet.** If you or your employer have questions about this form, please contact Susie Gaitan at (361) 354-2549 or by email at mgaitan@coastalbend.edu.

Name: _____ Daytime Phone Number: _____

Address: _____ Course Start Date: _____
Street City State Zip

Place of employment: _____ First date of employment: _____

Address of employer: _____ Administrator: _____
Street City State Zip

Daytime Phone Number: _____ Fax Number: _____

Please check all those that apply:

- ☐ I certify that the above name student applying for the Medication Aide course is employed by the facility named above
- ☐ The named student will be allowed to perform ten hours of clinicals for this medication aide course while she is working as a Certified Nursing Assistant in this facility.

The named student will be covered by the liability insurance provided by Coastal Bend College while s/he is performing ten hours of clinical for this medication aide course. This cost ($ 14.50) is included in the course fees.

_____
Please print or type the name of the Administrator

_____ _____
Signature of the Administrator Date

CE Form: MA 4

AFFADAVIT TO ANY FACT: THE STATE OF TEXAS

§ COUNTY OF _____

BEFORE ME, a Notary Public in _____County, Texas on this day personally appeared

_____(Name of Applicant), known to me to be the person whose name is subscribed to the Foregoing instrument, and having been by me first duly sworn on oath, acknowledge that the foregoing statements are true and correct:

I did see the original high school diploma or GED record and have attached a copy. GIVEN under my hand and seal of office, this _____day of _____, 20____.

Notary Public in and for _____County, Texas or _____.

_____Signature of Notary

_____Name of Notary printed

_____Commission Expiration Date

Seal of Notary above.

EXPERIENCE DOCUMENTATION REPORT FORM
TEXAS HEALTH & HUMAN SERVICES COMMISSIOM
MEDICATION AIDE PROGRAM - MAIL CODE E416
P. 0. BOX
149030
AUSTIN, TX 78714-9030

APPLICANT_____ SOCIAL SECURITY _____
TRAINING
SCHOOL_____
****

Form must be filled out in its entirety by the individual certifying that the information submitted is correct.

I_____' certify that I have employed
(FACILITY ADMINXSTRATOR/PROGRAM DIRECTOR/DON)
_____from,_____to_____and that I know
(Applicant)
of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide; or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a non-licensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

1. Place of Employment._____

2. Address: _____
Street no. City State Zip

3. Phone Number including Area Code,_____

4. Type of Facility_____

5. Job Title of Applicant._____

6. Nurse Aide Certificate Number (if applicable) _____
Expiration date._____

7. Type of work performed (be specific) _____

On this _____ day of _____,20___, in_____
I certify under penalty of perjury that the information submitted is true and correct.

_____
SIGNATURE OF ADMINISTRATOR/PROGRAM DIRECTOR/DON
Facility Vendor Number_____

Before me, a Notary Public in_____County, Texas on this day
Personally appeared _____known to me to be the person
(ADMINXSTRATOR/PROGRAM DIRECTOR/DON)
whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____day of _____, 20____

_____
(Signature of Notary)

Photocopy if additional copies are needed 09/01/17

TEXAS HEALTH & HUMAN SERVICES COMMISSION
MEDICATION AIDE PROGRAM -MAIL. CODE E416
P.O. BOX 149030
AUSTIN, TX 78714-9030
512/438-2025

GENERAL STATEMENT ENROLLMENT FORM

All required forms must be completed and returned to the above address NO LATER THAN 20 DAYS after the date of the first scheduled class in which you are enrolled. Include a $25.00 NONREFUNDABLE combined application & examination fee made payable to the TEXAS HEALTH & HUMAN SERVICES COMMISSION (THHSC). If any portion of the application is incomplete, it cannot be processed.

1. NAME_____ 2. SOCIAL SECURITY # _____

3. MAILING ADDRESS_____
Street or P.O. Box

_____
City State Zip County

4. Home Telephone (with area code) _____ 5. Date of Birth_____

6. Name of approved training School _____ City _____

7. Date of First Scheduled Class of Instruction: _____

8. Are you able to read, write, speak and understand English? Yes _____ No _____

9 Are you at least 18 years old? Yes _____ No _____

10. Submit an Experience Documentation Report form documenting current employment of the first official day of the training program in a facility licensed under Health and Safety Code Chapter 242 in the capacity of a CERTIFIED NURSE AIDE or in a Assisted Living Facility licensed under Health and Safety Code 247, State Supported Living Center, or ICF-IDD facility as a non-licensed direct care staff person. (HOME HEALTH AGENCIES, STAFFING AGENCIES & HOSPITALS ARE NOT LICENSED FACILITIES UNDER THE MEDICATION AIDE REGULATIONS).

11. Submit an Experience Documentation Form documenting 90 days of employment in an Assisted Living Facility licensed under Health and Safety Code Chapter 247, State Supported Living Center or ICF-IDD facility as non-licensed direct care staff.. This employment must have been completed within the 12-month period preceding the first official class date. AN APPLICANT EMPLOYED AS A CERTIFIED NURSE AIDE IS EXEMPT FROM THE 90 DAY REQUIREMENT.

12. Submit a certified copy or a photocopy which has been NOTARIZED as a true copy of an unaltered original of a high school graduation diploma or transcript or a general equivalency diploma.

13. Are you, to the best of your knowledge, free of contagious diseases and in a suitable physical and emotional health to safely administer medications? Yes _____ No _____.

14. Are you listed on the Employee Misconduct Registry (EMR) as unemployable? Yes _____ No _____

15. Have you been convicted of a criminal offense listed in Texas Health & Safety Code § 250.006?
Yes _____ No_____ If yes list date_____ and Conviction _____

16. Have you received a copy of the Medication Aide Training Program Rules? Yes _____ No _____. If no obtain a copy from the training school or call this office.

With few exceptions, you have the right to request and be informed about the information that DADS obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask DADS to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004) To find out about your information and your right to request correction, please contact this office.

PLEASE READ CAREFULLY

In making application to the Department of Aging & Disability Services Medication Aide Program for the issuance of a permit as a Medication Aide, I have read and agree to abide by the Medication Aide Training Program Rules. I also agree to complete all application requirements and take all examinations necessary for the processing of my application. Upon issuance of a permit. I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (95.105). I further understand that the materials submitted for consideration become the property of the Department and are nonrefundable. I am aware of the schedule of fees (95.109) and understand that additional fees must be paid to keep the permit current.

I further agree that if issued a permit, upon the denial, suspension or revocation of that permit, I shall return the permit to the Department.

The information that I have provided in this application is truthful. I understand that to falsify any information submitted to DADS may result in voiding of this application and my failing to be granted a permit, or the revocation of my permit.

_____ _____

DATE SIGNATURE OF APPLICANT

THE STATE OF

COUNTY OF

BEFORE ME. The undersigned authority, on this day personally appeared _____ Known to me to the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledged that he/she had executed the same for the purposes and consideration therein ell pressed and the foregoing statements are true and correct.

Given under my hand and seal of office, this _____ day of _____, _____

Notary Public in and for _____ County, Texas of _____

_____

Signature of Notary

_____

Name of Notary

_____

Commission Expiration Date

09/01/17