



# DOCUMENTATION OF QUALIFIED MEDICATION AIDE PRACTICUM

State Form 51650 (R3 / 2-24)  
INDIANA DEPARTMENT OF HEALTH  
CONSUMER SERVICES & HEALTH CARE REGULATION

This form must be uploaded with your application to test.

Student Name: \_\_\_\_\_

IDOH Approved QMA Training Program: \_\_\_\_\_

Practicum Site: \_\_\_\_\_

TOTAL PRACTICUM HOURS: \_\_\_\_\_

**Read Directions Carefully:** List **complete** dates (including year) and complete times (including am or pm). Document **only** time spent performing duties & tasks as mandated in the IDOH QMA program. Use the “Task #s” on the “QMA Procedure Performance Checklist” to document completed tasks in the “Description of Tasks Completed” column. **Do Not include time spent on other duties, breaks or meals.** Use multiple forms as necessary.

A maximum of two **4-hour increments**, which **must be divided by at least a 30-minute break**, may be completed in a 24-hour period of time.

Date	Start Time	Ending Time	Total Time	Description of Tasks Completed	Practicum Supervisor Printed Name	Practicum Supervisor Nursing License #	Practicum Supervisor Signature	Student Initials

Total Practicum Hours: \_\_\_\_\_

I verify that the above stated hours are correct and are the actual times of medication and treatment administration.

RN QMA Training Program  
Instructor Signature \_\_\_\_\_

Student Signature \_\_\_\_\_

Date \_\_\_\_\_