**INDIANA STATE DEPARTMENT OF HEALTH**
**LONG TERM CARE**
**Test Application for Qualified Medication Aide**
**State Form 17213 (R4/2-03)**
Form approved by State Board of Accounts-2001

## SECTION 1: APPLICANT INFORMATION

Applicant's LEGAL Name:_____ Sex: _____F _____ M
Last First M.I.

Address:_____ Phone#: (___)_____

City, State, Zip: _____ County: _____

Birth Date: _____ CNA Registry #: _____ SS#: _____

*PRIVACY NOTICE TO APPLICANT: The Indiana State Department of Health is requesting disclosure of your Social Security Number to accomplish its purpose under IC4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

## SECTION 2: COURSE INFORMATION (60 HOUR CLASSROOM EDUCATION)

Facility/School Name (no abbreviations):_____ Phone#: (___)_____

Address:_____ ISDH QMA Training #: _____

City, State, Zip: _____ County: _____

Date of Classroom Completion: _____ RN Instructor's PRINTED Name: _____

I verify that the above named applicant has successfully completed at least 60 hours of classroom instruction using ISDH approved training materials and that a summary of all assessment tools and checklists are completed and available in this applicant's file.

_____ _____ _____
RN Instructor's Signature (must be in red ink) RN Instructor's License # Date

## SECTION 3: COURSE INFORMATION (40 HOUR PRACTICUM)

Facility Name: _____ Phone#: (___)_____

Address:_____ ISDH QMA Training #: _____

City, State, Zip: _____ County: _____

Date of Practicum Completion: _____ Nurse Supervisor's PRINTED Name: _____

I verify that the above named applicant has, under my supervision, successfully completed at least 40 hours of practical experience administering medications and performing procedures according to ISDH approved training materials.

_____ _____ _____
Nurse Supervisor's Signature (must be in red ink) Nurse License # Date

## SECTION 4: APPLICANT VERIFICATION

I verify that all of the above information is correct. I understand that falsification of this document may result in denial or revocation of my qualification.

Applicant's Signature: _____ Date: _____

## SECTION 5: CANDIDATE STATUS

□ **100 HOUR CLASS**
□ **Psychiatric Attendant**
□ **Other:** _____
□ **Out-of-State QMA - State:** _____
□ **Nursing Student - School:** _____
□ **Foreign Nurse - Country:** _____

## SECTION 6: DOCUMENTATION

**The following required documents are included with this request to test:**

□ **Original** Application
□ **Original** documentation of practicum
□ Copy of High School Diploma, GED or transcript
□ Copy of current Indiana Nurse Aide Registry certification letter

Nursing Students and Out-of-State QMAs must also include:
□ **Original** ISDH approval letter & all documentation initially submitted to ISDH

Include testing fee of $60.00 (money order) **payable to Professional Resources**. Personal checks are **not** accepted.
Send all documentation and fee to: **Professional Resources, PO Box 1552, Valparaiso, IN 46384-1552**

## SECTION 7: TEST RESULTS

**FIRST TESTING**

| | |
|---|---|
| **Test Entity** | |
| **Tester** | **Test Date** |
| **Test Site** | **County** |
| **WRITTEN TEST RESULTS: PASS _____ FAIL _____** | **SCORE:_____** |

**SECOND TESTING**

| | |
|---|---|
| **Test Entity** | |
| **Tester** | **Test Date** |
| **Test Site** | **County** |
| **WRITTEN TEST RESULTS: PASS _____ FAIL _____** | **SCORE:_____** |

**THIRD TESTING**

| | |
|---|---|
| **Test Entity** | |
| **Tester** | **Test Date** |
| **Test Site** | **County** |
| **WRITTEN TEST RESULTS: PASS _____ FAIL _____** | **SCORE:_____** |