

OKLAHOMA STATE DEPARTMENT OF HEALTH • NURSE AIDE REGISTRY
Application for Advanced Training Certificate
Certified Medication Aide
Nasogastric/Gastrostomy/Oral Metered Dose Inhaler/Nebulizer

TRAINEE INFORMATION

Name: _____ Social Security Number: _____

Address: _____

City, State & Zip: _____ Phone: Area Code () _____

I completed the CMA Advanced Training Program indicated on this application and request issuance of an advanced training certificate.

Signature of Trainee: _____

Date: _____

TRAINING INFORMATION

Please check (√) the training program completed and indicate the number of training hours completed per 310:677-13-4(d)

_____ **Training on administration of medications and nutrition via nasogastric and gastrostomy tubes and Training on administration of oral metered dose inhalers and nebulizers.** (A combined minimum of 6 hours of classroom and supervised practical training.)

Total
Hours

Training Instructors Name: _____ Tele #() _____

Training Program Code: _____ Training Program Name: _____

Training Program Address: _____

TRAINING VERIFICATION STATEMENT

I verify that the above named CMA trainee has completed the training program indicated on this form on the date identified and that the training program has been **approved by the Oklahoma State Nurse Aide Registry.**

Date Trainee Started Training: _____ / _____ / _____ Completed Training: _____ / _____ / _____

RN Training Instructor/Supervisor's Signature

RN's License Number & Expiration

Area Code ()

RN Training Instructor/Supervisor's Telephone Number

RN's Social Security Number

Submit with a \$10 non-refundable certification fee when completed to:
Oklahoma State Department of Health • Nurse Aide Registry • 1000 N.E. 10th Street • Oklahoma City, OK 73117