

NURSE AIDE EMERGENCY RULE

TRAINING EXCEPTION APPLICATION (limited to Emergency Rule only)

(h) Unlicensed health professionals under this section seeking certification may, at any time, but not later than 120 days following the lifting of the declaration of emergency, submit a training exception request and sit for the competency examination pursuant to OAC 310:677-1-3(c).

Please check the type of endorsement you are requesting. If approved, you are eligible for placement on the Nurse Aide Registry. (For placement you must have taken the test to become certified as a CMA through the waiver program or already certified as a CMA and have worked as a CMA and an Advanced CMA aide for at least 3 months). You must turn in your Skill Performance Check list showing the advanced certified medication aide endorsement you are applying for have been taught and found you were proficient in the skill and medication pass worksheet for those advanced skills. It must be signed by the RN the trainee will be working under and the trainee. You also must be currently certified as a LTCA, HHA, or DDDCA, and meet the eligibility requirements. Please sign the appropriate Affirmation, which is attached.)

- | | |
|---|--|
| <input type="checkbox"/> CMA – Insulin Administration/Glucose Monitoring - \$15 fee
<i>*Upon approval a letter will be mailed for the aide to complete the Insulin Administration (IA) Exam before being added to the registry for IA.*</i> | <input type="checkbox"/> CMA Glucose Monitoring (Only) - \$15 fee |
| <input type="checkbox"/> CMA – Respiratory/Gastro - \$15 fee | <input type="checkbox"/> CMA NASO Gastric (Only) - \$15 fee |
| | <input type="checkbox"/> CMA – Respiratory (Only) - \$15 fee |

Please include the following:

- CMA – Medication Skills Performance Checklist with Advanced Skills (Signed & Dated) and Medication Pass Worksheet** for those skills
- A Non-Refundable \$15.00 processing fee /fees**

Name (Please Print): _____ SSN: ____/____/____ Date of Birth: _____

Address: _____

City _____ State _____ Zip _____

Signature: _____ Date: _____

E-mail Address: _____

Affirmation

To be eligible for a training exception for placement on the Oklahoma Nurse Aide Registry as an Advanced Medication Aide, you must have a current nurse aide certification in Long Term Care Nurse, Home Health, and/or Developmentally Disabled Direct Care.

I affirm the information on this form to be true and correct to the best of my knowledge.

X _____ / / _____
Signature of Nurse Aide Date

***Please attach this completed form with the requested documents and the Non-refundable processing fee/fees, and mail to the Oklahoma State Health Department at the above address.**

(8/10/20)
Draft