Oklahoma Association of Health Care Providers

Certified Medication Aide (CMA) Training Program 2018

General Information

The Oklahoma Association of Heath Care Providers (OAHCP) Certified Medication Aide (CMA) Training Program is a fifty-seven and a half (57.5) hour program, 25.5 hours classroom and 32 hours clinical training and is approved by the Oklahoma State Department of Health.

The training program's purpose is to: 1) prepare certified nurse aides (CNAs) to pass the certified medication aide (CMA) certification exam; 2) to prepare the certified nurse aide to be qualified to be listed on the Oklahoma Nurse Aide Registry as a certified medication aide and 3) prepare the certified nurse aide to perform the duties of a certified medication aide in sittings approved via the Oklahoma State Department of Health.

Qualifications for admission to this program include: 1) to be able to read, write, and speak English, 2) current listing in good standing on the Oklahoma Nurse Aide Registry as a long term care (LTC), home health (HH) or developmentally disabled care (DD) aide; 3) minimum age of eighteen (18); 4) minimum of a high school or general equivalency diploma (GED); 5) experience working as a CNA for at least six (6) months; and 6) physically and mentally capable to safely perform the duties of a CMA.

Competency testing *is required u*pon successful completion of this program. The trainee is required to pass (70%) the state approved written examination offered via a state approved testing entity. Upon completion of the training program trainees will be given the forms and information needed to schedule an appointment to test at the career tech test site of their choice. ***There is an additional cost for this written examination which is responsibility of student or facility.***

Classroom and Clinical Training -Trainees will attend two days of classroom training, day one and day two, then return to the facility to complete sixteen (16) hours of clinical training. Approximately twelve days later, the trainee will return for the last two days of classroom training, day three and four; and then the trainee returns to the facility for the final sixteen (16) hours of clinical training and the final drug pass. **The facility must be in good standing with no record of substandard of care citations to provide clinical training**.

Final drug pass -After completion of classroom and clinical training, the trainee must pass medications to 20 consecutive individuals with 100% accuracy while under the direct supervision of the approved clinical instructor. **(This medication pass is done AFTER all classroom and clinical training are completed)**. This pass is the final medication pass test to assure the trainee performs the medication pass proficiently and must be completed at 100% accuracy prior to taking the written exam.

If the trainee does not perform the drug pass at 100% proficient the first time, the pass can be performed up to three (3) times. If not performed at 100% proficiency by the third time, the trainee has failed the program and may not sit for the written exam.

Clinical Instructors and Site - **Each registrant to the CMA training program must be sponsored** by a licensed long term care, developmentally disabled, assisted living or residential care facility. Upon registration of a CNA to this program, a **facility** must:

1. **Complete a "Clinical Site Request Form", to request approval of the facility as the clinical site for the trainee; and**

2. **Complete an "Instructor Qualification Form", <u>to designate a qualified individual willing to serve as the clinical instructor for the trainee.</u> This individual will be the clinical instructor during the thirty-two (32) hours of clinical training and will administer the final drug pass.**

<u>Facility Instructor Qualifications -Instructors must be a physician, licensed nurse or pharmacist and have at least one year's experience in their area of expertise. If an LPN serves as instructor, an RN must be designated as the training program supervisor.</u>

<u>Clinical Completion Time Frame</u> - All clinical hours and the final drug pass should be completed and all forms returned to OAHCP <u>within thirty (30) days of the last day of classroom work</u>.

Once successful program completeness is verified via OAHCP, the necessary testing verification forms, instructions and test site locations and contacts will be returned to the clinical instructor. Arrangements must be made by the facility/trainee/clinical instructor to sit for the written examination.

<u>Written Examination</u> -The state required exam for CMA certification may only be administered by a state approved testing entity. ***<u>There is an additional cost for this written examination which is responsibility of student or facility.</u>*** Each trainee has three (3) opportunities to pass the written exam before having to complete another training program.

Upon passing the written exam, the testing entity will notify the trainee and Oklahoma State Department of Health (OSDH) Nurse Aide Registry for listing on the registry. The OSDH Nurse Aide Registry will mail the CMA certification card to the new CMA.

DATES and LOCATION 2018: <u>(All 4-days of training must be completed for completion)</u>

February 1, 2, 15 & 16 – OKC – Oklahoma Assn. of Health Care Providers office (#3060)
May 7, 8, 21 & 22 – Tulsa – OSU-Tulsa – Confence Center Entrance – Room 153 (#3061)
October 15, 16, 29 & 30 – OKC – Oklahoma Assn. of Health Care Providers office (#3062)

TIME:	**Check-in - 8:00 to 8:30 a.m.**
	Class - 8:30 a.m. to 4:00 p.m.
	<u>NO ADMITTANCE after 8:45 a.m.</u>
COST:	**$285.00 per Member Facility Participant**
	$385.00 per Non-Member Facility Participant
	Includes Course Materials & Lunches
COURSE APPROVAL:	**Oklahoma State Department of Health**

<u>REGISTRATION/PAYMENT DEADLINE DATE</u>:
Registration and payment <u>deadline is 5 business days</u> before first class day. NO PERSONAL CHECKS please. ***<u>Registration and payment must be received in advance of class or participant will not be allowed to attend.</u>*** Course materials will not be available for those not pre-registered.

<u>CANCELLATION FEES</u>: Cancellations received before 10 days of class date will receive full refund; cancellations received within 10-days of class date will receive refund minus $65 (member) or $130 (non-member). Cancellations MUST BE FAXED (405-524-8354) or EMAILED to ccook@oahcp.org. Substitutions may be made with proper paperwork prior to class. Refunds will not be issued if cancellation is not received into OAHCP office before first class start date. No-shows will not receive credit/refund.

NOTE: This course does not include the "Advanced Training" for care of diabetes, administration of medications and nutrition via nasogastric and gastrostomy tubes, or for administration of oral metered dose inhalers and nebulizers because state rules require an individual to be certified as a Medication Aide prior to completion of advanced CMA training. These "Advanced Training Programs" are offered by the OAHCP – visit our website at www.oahcp.org or contact the association for more information.

LODGING:

Room reservations are the responsibility of each individual. A listing of hotels can be found at www.oahcp.org – Education – Hotel Listings.

Participants should bring a sweater or light jacket since room temperatures are often difficult to control.

Class check-in 8:00 a.m. to 8:30 a.m. – Class 8:30 a.m. to 4:00 p.m. – NO admittance after 8:45 a.m.

On-line registration NOT AVAILABLE for this program

Oklahoma Association of Health Care Providers

CERTIFIED MEDICATION AIDE CERTIFICATION COURSE

2018 REGISTRATION FORM

Please copy if additional forms are needed.

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February 1, 2, 15 & 16 – OKC – Oklahoma Assn. of Health Care Providers office (#3060)
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NURSE AIDE **(PRINT NAME):** ____

NURSE AIDE CERTIFICATION #:_______________________________ Expiration ___________

NURSING FACILITY: ____ CITY: ____________

NURSING FACILITY PHONE #: (_____)_________________FAX #: ______________________

E-MAIL ADDRESS: ____

****Designated Clinical Instructor and Title: (RN, LPN, D.Ph.)_________________________**
(PRINT)

****Please fax/mail: Registration form, Attestation form, Instructor qualification form & copy of licenses (RN & LPNs), Clinical site request form, COPY of the candidates' current (not expired) NURSE AIDE CARD**** with $285.00 per member facility participant or $385.00 per non-member facility participant to: **(Make checks/money orders payable to OAHCP)**

Oklahoma Association of Health Care Providers – 1201 North Harvey Ave. – OKC, OK 73103
(405) 524-8338 / Fax: (405) 524-8354

REGISTRATION/PAYMENT DEADLINE DATE:
Registration and payment deadline is 5 business days before first class day. NO PERSONAL CHECKS please. ***Registration and payment must be received in advance of class or participant will not be allowed to attend.*** Course materials will not be available for those not pre-registered.

CANCELLATION FEES: Cancellations received before 10 days of class date will receive full refund; cancellations received within 10-days of class date will receive refund minus $65 (member) or $130 (non-member). Cancellations MUST BE FAXED (405-524-8354) or EMAILED to ccook@oahcp.org. Substitutions may be made with proper paperwork prior to class. Refunds will not be issued if cancellation is not received into OAHCP office before first class start date. No-shows will not receive credit/refunds.

TIME: Check-in 8:00 a.m. to 8:30 a.m. Class 8:30 a.m. to 4:00 p.m. (No admittance AFTER 8:45 A.M.)

Forms that MUST accompany registration and payment: **Copy of CNA card, Signed attestation form, Instructor qualification form & copy of license (RN &LPNs), and Clinical site request form.**

Attestation for Certification as a Medication Aide

The Oklahoma Administrative Code at Title 310:677-13-8 sets the following prerequisites for certification as a medication aide: As a **candidate** of the Certified Medication Aide certification course conducted by the Oklahoma Association of Health Care Providers, I do attest that the following statements are true to the best of my knowledge.

(1) Minimum age of 18
(2) Minimum education: high school or general equivalency diploma (GED)
(3) Current Oklahoma nurse aide certification with no abuse notations
(4) Experience working as a certified nurse aide for six months
(5) Physical and mental capability to safely perform duties

Please be certain that the information above is correct. The Oklahoma State Department of Health may deny, suspend, withdraw or not renew the certification of a medication aide who intentionally provides false or misleading information to a training program, a facility, or the Oklahoma State Department of Health.

Note: If the answer to any of the questions above is "NO" this applicant is not qualified for certification as a medication aide.

By my signature below, I certify that the foregoing is true, correct and complete to the best of my knowledge and belief.

Candidates Signature:____

Print Name: ________________________________**Date of Signature:** ______________

Nurse Aide Certification #: ____

FACILITY ADMINISTRATOR:

As the **Administrator** of the sponsoring facility, I do attest that the above statements are true to the best of my knowledge and have contacted the Nurse Aide Registry at (800-695-2157 or 405-271-4085) to verify that there are no records of abuse on the applicant's record.

Administrator's Signature: ____

Print Name: _________________________________**Date of Signature:** _______________

Forms that MUST accompany registration and payment: Copy of CNA card, Signed attestation form, Instructor qualification form & copy of license (RN & LPN), and Clinical site request form.

Mail/fax to: OAHCP
1201 North Harvey Ave. Oklahoma City, OK 73105
405-524-8338 phone 405-524-8354 fax
www.oahcp.org

Credit Card Information

Facility name: ____ Individual name:___________________

CVV Code:________ Billing Zip Code: __________ Amount to be charged $____________

Card # ____ Expiration date: ___________

Cardholder name: ___________________________ Signature: _____________________________________

For Office Use Only

Date: _________________________

Approval code: _____________________

Class number: __________________

Initials: ______________

Oklahoma Association of Health Care Providers
CMA Training Program

Clinical Site Request Form

Licensed Facility Name: ____

City/State/Zip Code: ______________________________ __________ __________
City State Zip

Contact Person:____

Phone Number: (____) ________________________Fax: (____) ______________

E-mail Address: ____

Signature of Administrator:
This form must be signed by the administrator as agreement to use the above named licensed nursing facility for clinical training and the final medication pass evaluation.

My signature verifies that I am the administrator of this licensed facility and I agree that the CNA we are registering for the ***"OAHCP CMA Training Program"*** may use this facility for CMA clinical training and for the final medication pass evaluation.

Administrator's Signature: ____

Date: ______________________________

Oklahoma Association of Health Care Providers
CMA Training Program

Facility Instructor Qualification Form

Facility Name (if applicable):____

Facility Mailing Address: ____

City: ____State: ________Zip: _____________

Contact Person: ____

Phone Number (_____) ___________________________ Email Address_____________________________________

Instructors shall be qualified as a physician, licensed nurse, pharmacist, respiratory therapist, speech therapist or certified diabetes educator who may teach within their area of expertise and have at least **one year's experience** in their area of expertise. Other persons from the health professions may supplement the instructor as required by the curriculum and approved by the Department. If an LPN serves as instructor an RN must be designated as the training program supervisor.

*Complete the information below for **each instructor** to approve, i.e. up to three per page.* ***Please, attach a readable copy of licenses*** *(RN & LPN).* ***All instructors must be listed below.*** *You may copy this page if you have more than three instructors.*

Instructor Name: ____Qualification: ______________

Years experience in area of expertise: ___________ License # _______________________ ***Attach Copy of License.***

Instructor Name: ____Qualification: _____________

Years experience in area of expertise: ___________ License # _______________________ ***Attach Copy of License.***

Instructor Name: ____Qualification:________________

Years experience in area of expertise: ___________ License # _______________________ ***Attach Copy of License.***

IF LPN serves as instructor, an RN must be designated as a supervisor and include copy of license.

RN Supervisor's Name: ______________________________License # _____________ ***Attach copy of license.***