

**INITIAL MEDICATION ASSISTANT I & II APPLICATION**

North Dakota Department of Health
 Division of Health Facilities
 SFN 59962 (R2-2012)

Class Roster Match with app

Yes _____ No _____

Please Check One

- Medication Assistant I - Must be an NA or CNA - (Non-Refundable Fee \$25.00)
 Medication Assistant II - Must be a CNA - (Non-Refundable Fee \$25.00)

PLEASE CHECK THE REGISTRY CATEGORY YOU CURRENTLY HOLD:

- Certified Nurse Aide (CNA):Registry Number _____ Expiration Date _____
 Nurse Aide (NA) Registry Number _____ Expiration Date _____

APPLICANTS, PLEASE COMPLETE ALL INFORMATION BELOW (Please print legibly)

First Name	Last Name	Maiden/Middle Initial	M	F
Current Mailing Address (Include C/O Address)			County	
City	State	Zip Code	Social Security Number (Required)	
Date of Birth	E-Mail Address			
Home Phone	Work Phone	Cell Phone		
Name of Employer		City	State	
Employer's Contact Name		Employer's Phone Number		

ALL QUESTIONS BELOW MUST BE COMPLETED BY APPLICANT

1.	Have you ever been arrested, charged, or convicted of a felony (<i>You must answer yes if the felony arrest or felony charge resulted in a plea agreement, misdemeanor, nolo contendere, deferred imposition, or other action</i>) within the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2.	Has your registration or nursing license been sanctioned or disciplined by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3.	Have you had a nurse aide registry listing or unlicensed assistive person registry listing marked for abuse, neglect, or misappropriation of property?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4.	Have you been investigated or are you presently being investigated by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5.	Have you been denied registration or licensure by any other jurisdiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6.	Have you, in the last two (2) years, been terminated from a nurse aide or nursing related job due to conduct that may be grounds for disciplinary action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7.	Have you, in the last two (2) years, been diagnosed with chemical dependency or participated in chemical dependency treatment/rehabilitation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8.	Have you, in the last two (2) years, been diagnosed with or treated for a mental health or physical condition which adversely affected your ability to safely provide nurse aide services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9.	If you answered "Yes" to any of the above questions, please attach a detailed written explanation and any legal documents to the application and send to the North Dakota Department of Health for review. Have you attached the appropriate documents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

APPLICATION CERTIFICATION

I certify the information provided is true, correct, and complete, and I understand that submission of any false or incomplete information may be grounds for disciplinary action.

Applicant Signature

Date

FOR STATE USE ONLY

Date Received _____ Amount Received \$ _____ Cash MO or CK# _____

Medication Assistant Training Program

Name of Medication Assistant Training Program			
Address	City	State	Zip Code
Date of Enrollment	Date of Completion		

Registered Nurse Instructor/Program Supervisor

Name	Registered Nurse Number
E-mail Address	Phone Number
Signature	Date

NOTE: Please attach a copy of a Certification of Completion and/or a Class Roster or letter demonstrating successful completion of an approved Medication I or II Training Program.

Please remit \$25 (U.S. dollars) Non-refundable Fee

Make checks and/or money orders payable to the North Dakota Department of Health.

All completed forms and checks or money orders must be sent or delivered together to:

**North Dakota Department of Health
Division of Accounting
600 East Boulevard Ave., Dept. 301
Bismarck, ND 58505-0200**

If you have questions or wish to contact the Department of Health, please phone 701.328.2353 or contact us by e-mail at naregistry@nd.gov