FEES ARE NON REFUNDABLE

1705 001- $ 90.00
006- $ 10.00
$ 10.00
$110.00

Department of Health
Division of Health Licensure and Regulation
Tennessee Board of Nursing
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

Application for Certification as a Medication Aide

*Submit application **AFTER** obtaining certification*

Print Legal Name (*use ink*): _____
LAST FIRST MIDDLE MAIDEN

List any other names by which you have been known:_____

Social Security Number: _____ Telephone Number: (_____)_____
Your social security number may be used to verify your identity and for any other purpose allowed by state or federal law.

U.S. Citizen ❒ Yes ❒ No Entitled to Live and Work in the U.S. ❒ Yes ❒ No

Date of Birth: _____ Gender: ❒ Female ❒ Male

Ethnic Group: ❒ White ❒ Black ❒ Native American Indian ❒ Asian ❒ Hispanic ❒ Other, Specify _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file. You will no longer receive physical mail from our office. ❒ Yes ❒ No Email address: _____
(Print legibly)

Mailing Address: _____
(Street/PO Box/Route) (City/State/Zip)

Street Address: _____
(Required if Mailing Address is a PO Box) (Street) (City/State/Zip)

Have you completed 12th grade or its equivalent (GED)? ❒ Yes ❒ No

Are you at least 18 years of age? ❒ Yes ❒ No

Have you worked as a certified nurse aide in a nursing home, assisted living facility or a P.A.C.E. for at least 365 days of continuous uninterrupted full time work at no more than two different facilities? ❒ Yes ❒ No

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? *(If yes, provide proof of status*) ❒ Yes ❒ No

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? *(If yes, provide proof of status)* ❒Yes ❒ No

Have you previously applied for a medication aide certificate in Tennessee? ❒ Yes ❒ No

Are you or have you ever been certified as a medication aide in another state? ❒ Yes ❒ No
If yes, identify name as certified, state and certification number: _____

Are you or have you ever been licensed in any other profession in Tennessee or another state? ❒ Yes ❒ No
If yes, identify profession, name as licensed, state, license number and status: _____
_____

Education History

Medication Aide Training Program Name, City, State	Start Date mm/dd/yyyy	Completion Date mm/dd/yyyy	Certification Testing Date mm/dd/yyyy

CNA Work History

Facility	City & State	From Date mm/yyyy	To Date mm/yyyy

Definitions for Fitness and Competency Questions

1. “Ability to practice your profession" is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. “Medical Condition" includes physiological, mental or psychological conditions including, but not limited to; orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3."Minor Traffic Offense” generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. “Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. “Currently" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. “Illegal use of illicit or controlled substances" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

Fitness and Competency Questions

1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? ❒ Yes ❒ No

If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.

2.Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? ❒ Yes ❒ No If yes, please list: _____

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances? ❒ Yes ❒ No

4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances? ❒ Yes ❒ No

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature? ❒ Yes ❒ No

6. Have you ever held or applied for a license, privilege, registration or certificate in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? ❒ Yes ❒ No

7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? ❒ Yes ❒ No

8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? ❒ Yes ❒ No

9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? ❒ Yes ❒ No

10. Have you ever been rejected or censured by a professional association or society? ❒ Yes ❒ No

11. In relation to the performance of your professional services in any profession:
    a. Have you ever had a final judgment rendered against you;
    b. Have you ever entered into any settlement of any legal action; or
    c. Are there any legal actions pending against you or to which you are a party? ❒ Yes ❒ No

12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? ❒ Yes ❒ No

13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state). ❒ Yes ❒ No

If you answered "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. In support of your explanation, the board orders from the issuing states, the certified arresting document (warrant), judgment (disposition), and release from judgment (receipt of payment of fines, letter of release from probation, etc.) from the court (clerk's office), and/or agencies must be submitted along with this application. Additional information may be requested and/or required before a licensure decision may be made.

I, being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in my work as a medication aide in the State of Tennessee.

I HEREBY:
SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.
RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely work as a medication aide.
AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.
RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.
ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.
AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____

Signature Date