RENEWAL NOTICE

Department of Health & Human Services
Division of Public Health, Licensure Unit
Office of Nursing &Nursing Support
PO Box 94986
Lincoln, NE 68509-4986
Phone: (402) 471-4364 or (402) 471-4910
Fax: (402) 471-1066

Your registration as a (choose one) ☐ Medication Aide or ☐ Medication Aide-40 hour expires _____.
Registration # **:** _____

Full Name: _____
Street Address: _____
Mailing Address: _____
City, State, Zip code: _____

Include $18 non-refundable renewal fee. Make check or money order payable to "DHHS Licensure Unit." Submit at least 30 days before expiration date to ensure renewal on time.

Two Year Renewal

Name Changes: For name change, attach a copy of your marriage certificate, divorce decree, or court order. If this is not submitted, registration will be issued in the name that is currently in the licensure system.

Sections 1, 2, 3 and 4 are to be completed by you. Section 5 is completed by the Licensed Health Care Professional doing your competency assessment. You are responsible for making sure all sections are fully completed before mailing. ***If you have already expired use the reapplication form.

Section 1: Demographic Information

Fully complete the following information.

Social Security Number (Required): _____
Date of Birth: _____
Place of Birth: _____
Telephone Number: _____
Email address (optional): _____

Section 2: Background

Have you been convicted of a crime other than speeding in the last two (2) years? ☐ Yes ☐ No

If you answered YES, you MUST list the date of conviction, county/state in which the conviction occurred and the type of conviction(s). (Attach additional sheet(s) of paper if necessary to list crimes/convictions.) On an additional sheet of paper, please include a brief description of the conviction including what the conviction was for, what happened and who was involved. You **must** submit **certified** copies of the following information for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. *****Please note that a conviction is not necessarily a disqualification for placement on the Registry.*

Date of Conviction	County/State	Type of Conviction

Turn over to complete page 2 of renewal form.

Revised May 2014

Section 3: Attestation of Lawful Presence in the United States:

For the purpose of complying with Nebraska Revised Statutes §4-108 through §4-114, I attest as follows:

Please check the appropriate choice below:

_____ I am a citizen of the United States

_____ I am a qualified alien under the Federal Immigration and Nationality Act. My Immigration status is _____ and alien/USCIS number is _____-_____-_____. I agree to provide a copy of my United States Citizenship and Immigration Services documentation upon request.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Section 4: Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name of Applicant: _____

Applicant's Signature: _____ Date: _____

The following section is to be completed by the Licensed Health Care Professional conducting your competency assessment and/or directing a registered Medication Aide to conduct the competency assessment.

Section 5: Documentation of Competency Assessment

This is to certify that _____ has successfully demonstrated competency in the following areas:
(Print Medication Aide Applicant's Name)

Demonstrated the ten (10) competencies as identified in Nebraska Revised Statute §71-6725

1. Maintaining confidentiality,
2. Complying with a recipient's right to refuse to take medications,
3. Maintaining hygiene and current accepted standards for infection control,
4. Documenting accurately and completely,
5. Providing medications according to the five rights,
6. Having the ability to understand and follow instructions,
7. Practicing safety in application of medication procedures,
8. Complying with limitations and conditions under which a medication aide may provide medications,
9. Having an awareness of abuse and neglect reporting requirements, and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Demonstrated providing routine medications by the routes identified in Title 172, NAC 95-005.01

1. Oral (mouth, sublingual, buccal, sprays),
2. Inhalation (inhalers, nebulizers, oxygen),
3. Topical (sprays, creams, ointments, lotions, transdermal patches), and
4. Instillation (drops, ointments, and sprays in eyes, ears, and nose)

_____ _____ _____ _____
Signature of Licensed Health Care Professional | Profession | Professional License # | Date competency completed

_____ _____
Place of employment of Licensed Health Care Professional | Telephone number

If the competency assessment was conducted by a registered Medication Aide, the following information must be provided:

_____ _____ _____
Signature of registered Medication Aide conducting the competency assessment | Registry # | Date

_____ _____
Place of employment of Medication Aide conducting the competency assessment | Telephone number

Revised May 2014