

Documentation of Competency Assessment

This is to certify that

(Name of Medication Aide)

(Social Security #)

has successfully demonstrated each of the competencies as identified in Title
172 NAC 96, Section 005

on _____
(Date)

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY BEFORE COMPLETING

**To be completed by Licensed Health Care Professional conducting the
competency assessment and/or directing a registered Medication Aide to
conduct the competency assessment**

Signature of Licensed Health Care Professional

Health Care Profession

License #: _____

Place of employment of Licensed Health Care Professional

Work telephone number of Licensed Health Care Professional

**IF APPLICABLE to be completed by registered Medication Aide conducting
the competency assessment**

Signature of registered Medication Aide conducting the competency assessment

Registry #: _____

Place of employment of Medication Aide conducting the competency assessment

Work telephone number of Medication Aide conducting the competency assessment