



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

## Application for Medication Aide Registration

*Reminder: Include a check/money order for the \$18 non-refundable registration fee.  
 Make payable to DHHS Licensure Unit.*

### Section 1: Personal Information

(Please note that in order to change a name that is already on our system, we must have documentation of proof of name change.)

Name \_\_\_\_\_  
 Last First Middle Maiden Previously used names

Address: \_\_\_\_\_  
 Street Apt# City State Zip code

Telephone number: Home \_\_\_\_\_ Cell \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 (city/state)

### Section 2: Background

Have you been convicted of a crime other than speeding?  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

Have you provided medications without being active on the Medication Aide Registry?  Yes  No

If you answered yes, how many partial or whole days did you provide medications? \_\_\_\_\_  
 Please explain why you have been providing medication without being registered as a Medication Aide \_\_\_\_\_

### Section 3: Applicant's 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 and/or the 40-hour course completion, if applicable.

**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

**Medication Aide 40-Hour Course Completion** – According to Nebraska Revised Statute §71-6725(4) to work in assisted living facility, a nursing home, or an intermediate care facility for persons with developmental disabilities, the applicant must have completed a 40-hour course. Please complete the following as documentation of course completion if the applicant wishes to be authorized to work in these settings.

\_\_\_\_\_  
Name of College or Facility Providing the Training Program                      Date of Completion

\_\_\_\_\_  
Instructor's Signature                      Profession and License Number