



INDIANA STATE DEPARTMENT OF HEALTH
LONG TERM CARE
Test Application for Qualified Medication Aide
State Form 17213 (R4/2-03)
Form approved by State Board of Accounts-2001

SECTION 1: APPLICANT INFORMATION

Applicant's LEGAL Name: _____ Sex: ____ F ____ M
Last First M.I.

Address: _____ Phone#: (____) _____

City, State, Zip: _____ County: _____

Birth Date: _____ CNA Registry #: _____ SS#: _____

*PRIVACY NOTICE TO APPLICANT: The Indiana State Department of Health is requesting disclosure of your Social Security Number to accomplish its purpose under IC4-1-8. Disclosure is voluntary and you will not be penalized for refusal.

SECTION 2: COURSE INFORMATION (60 HOUR CLASSROOM EDUCATION)

Facility/School Name (no abbreviations): _____ Phone#: (____) _____

Address: _____ ISDH QMA Training #: _____

City, State, Zip: _____ County: _____

Date of Classroom Completion: _____ RN Instructor's PRINTED Name: _____

I verify that the above named applicant has successfully completed at least 60 hours of classroom instruction using ISDH approved training materials and that a summary of all assessment tools and checklists are completed and available in this applicant's file.

RN Instructor's Signature (must be in red ink) RN Instructor's License # Date

SECTION 3: COURSE INFORMATION (40 HOUR PRACTICUM)

Facility Name: _____ Phone#: (____) _____

Address: _____ ISDH QMA Training #: _____

City, State, Zip: _____ County: _____

Date of Practicum Completion: _____ Nurse Supervisor's PRINTED Name: _____

I verify that the above named applicant has, under my supervision, successfully completed at least 40 hours of practical experience administering medications and performing procedures according to ISDH approved training materials.

Nurse Supervisor's Signature (must be in red ink) Nurse License # Date

SECTION 4: APPLICANT VERIFICATION

I verify that all of the above information is correct. I understand that falsification of this document may result in denial or revocation of my qualification.

Applicant's Signature: _____ Date: _____

SECTION 5: CANDIDATE STATUS

<input type="checkbox"/> 100 HOUR CLASS <input type="checkbox"/> Psychiatric Attendant <input type="checkbox"/> Other: _____	<input type="checkbox"/> Out-of-State QMA - State: _____ <input type="checkbox"/> Nursing Student - School: _____ <input type="checkbox"/> Foreign Nurse - Country: _____
---	--

SECTION 6: DOCUMENTATION

The following required documents are included with this request to test:

<input type="checkbox"/> Original Application	<input type="checkbox"/> Copy of High School Diploma, GED or transcript
<input type="checkbox"/> Original documentation of practicum	<input type="checkbox"/> Copy of current Indiana Nurse Aide Registry certification letter

Nursing Students and Out-of-State QMAs must also include:
 Original ISDH approval letter & all documentation initially submitted to ISDH

Include testing fee of \$60.00 (money order) **payable to Professional Resources**. Personal checks are **not** accepted.
 Send all documentation and fee to: **Professional Resources, PO Box 1552, Valparaiso, IN 46384-1552**

FIRST TESTING

SECTION 7: TEST RESULTS

Test Entity		
Tester	Test Date	
Test Site	County	
WRITTEN TEST RESULTS:	PASS _____	FAIL _____
	SCORE: _____	

SECOND TESTING

Test Entity		
Tester	Test Date	
Test Site	County	
WRITTEN TEST RESULTS:	PASS _____	FAIL _____
	SCORE: _____	

THIRD TESTING

Test Entity		
Tester	Test Date	
Test Site	County	
WRITTEN TEST RESULTS:	PASS _____	FAIL _____
	SCORE: _____	