Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

MEDICATION AIDE APPLICATION INSTRUCTIONS

1. **Complete the entire application in ink or typed print.**

2. **Non-Refundable $50 Application Fee** payable to "Treasurer, State of Ohio" must accompany this application. **Personal checks or cash will not be accepted**. Send a certified check, cashier's check or money order. Business checks from government entities, corporations, and education or training programs will be accepted. Payments must be drawn on a United States (U.S.) bank and payable in U.S. dollars. Please do not staple your payment to the application.

3. **Affidavit** The affidavit must be signed and notarized after completion of the entire application.

4. **Program Completion (Form A)** Attestation of Medication Aide Training Program Completion. Part 1 must be completed by the applicant and sent to the medication aide training program. Part 2 must be completed and submitted directly to the Board by the training program representative. Form A will not be accepted from the applicant.

5. **Board Approved Examination Test Results** Verification of Passing a Certification Examination must be sent directly to the Board by the national testing/certifying organization or by the Medication Aide Training Program.

   Please note: *(within sixty (60) days of satisfactorily completing the required classroom and supervised clinical practice components, the student shall take a board approved examination).*

6. **Criminal Records Check** A BCI (civilian) and FBI (federal) criminal records check is required for all applicants. Refer to the attached instructions regarding criminal records check unless you have already had them done and they have been submitted to the Board.

Processing Information

It is the **applicant's responsibility** to insure that all required documents are received by the Board **directly from** the appropriate agency. Please **DO NOT** send documents that are not requested in this application such as your birth certificate or a copy of your diploma.

If any part of this application is incomplete, the application may be returned. To determine if your application has been received and reviewed, please go to the Board website at www.nursing.ohio.gov, click on "verification" and enter ONLY your name. Once your name appears, it will display as "pending" until your medication aide certificate is issued.

The application is void and the fee is forfeited if the requirements for a Medication Aide certificate are not met within one year from the date the application is received by the Board.

Name & Address Change - Notify the board in writing within 30 days of any name change or address change. A name change requires a certified copy of documentation such as a marriage certificate, court record or a divorce decree. **A photocopy or notarized copy is not acceptable.**

For questions about the application or instructions, please contact Angela White at (614) 466-6966 or by Email at awhite@nursing.ohio.gov.

Return completed application to:

Ohio Board of Nursing
Attention: MAC
17 South High Street, Suite 400
Columbus, Ohio 43215 - 7410

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CRIMINAL RECORDS CHECKS REQUIRED FOR LICENSURE OR CERTIFICATION

If you have already completed your background checks, please disregard this letter. If you have not completed your background check, please read on.

The Ohio Revised Code requires those applying for a license or certificate issued by the Ohio Board of Nursing (Board) to submit fingerprints for an FBI (federal) and BCI (civilian) criminal records check completed by the Bureau of Criminal Identification and Investigation (BCI). The Board cannot, by law, complete the processing of your application until the Board receives **BOTH** background check reports.

BCI will **ONLY** accept electronic fingerprints for **FBI and BCI** background checks, except for the reasons listed below. Electronic fingerprints must be completed by a Webcheck location in Ohio that will submit the applicant's fingerprints electronically to BCI. The applicant must request that **BOTH** reports be sent to the Board **DIRECTLY** from BCI, or they will not be accepted by the Board. A complete list of Webcheck locations is available online at the following website address:
www.ohioattorneygeneral.gov/Services/Business/WebCheck/Webcheck-Community-Listing
When locating an electronic fingerprinting site on this web page, please note that only the locations designated with the notation of "BCI & FBI" perform both the BCI and FBI records check. The Board does not endorse or recommend any specific Webcheck fingerprinting company.

Fingerprint cards will only be accepted by BCI (with an Exemption Form) for one of the following reasons:

- Applicant's home address is 75 miles or more from the nearest Webcheck location;
- Amputations or digits missing (Webcheck 4.0 only);
- Out-of-state applicant;
- Poor quality prints (Not able to capture at Webcheck location, provide name of location where the background check was attempted on the waiver form);
- BCI/FBI rejects from original electronic submission. **Note**: The original reject letter must accompany the fingerprint card (s); and
- Public Housing Organization background checks.

Waivers of the electronic submission requirement will be evaluated on a submission by submission basis. No "blanket" or agency-wide waivers will be granted. Exemption requests that are denied will be returned to the submitting agency. Any card that is submitted without a waiver form will also be returned. **Please note:** If you have questions about any of the qualifying exemptions, please contact BCI at **(877) 224-0043.**

If you meet any of these exemptions, please submit your name and complete address to the Board in writing (Attention: CRC) at the above address, by fax at (614) 466-0388, or by email at crc@nursing.ohio.gov to request fingerprint cards and instructions for completing the cards.

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Application For A Certificate To Function As A
CERTIFIED MEDICATION AIDE In Ohio

1.) GENERAL INFORMATION (Complete the entire application in ink or typed print)

Full Legal Name_____
Last First Middle Maiden

Social Security Number*_____

Address_____

City_____State_____Zip_____

County of Residence_____

Telephone Number_____Email Address_____

Date of Birth_____Place of Birth_____
City State Country

Gender ☐ Female ☐ Male

Race/Ethnicity (If more than one applies, mark "other")

☐ African American/Black ☐ Asian-Indian ☐ Hispanic/Latino ☐ Other
☐ American Indian or Alaska Native ☐ Caucasian/White ☐ Native Hawaiian or Other Pacific Islander ☐ I do not wish to furnish this information

2.) CITIZENSHIP **

☐ United States
☐ Alien lawfully admitted for permanent residency in the United States
(attach a copy of the front and back of alien registration card or work authorization card)
☐ Other non-immigrant status (attach copy of documentation)
☐ I am a foreign national not living in the United States

3.) HIGH SCHOOL OR EQUIVALENCE

Name of High School_____ **(OR)** GED
City/State_____ City/State_____
Date of Graduation (Month/Year)_____ Date Taken (Month/Year) _____

4.) MILITARY SERVICE (if applicable)

☐ I am a member or former member of the armed forces of the United States, the national guard or a reserve component
(attach a copy of a military document, for example, an ID card (DD Form 2) or Certificate of Release or Discharge from Active Duty (DD Form 214)).
☐ I am the spouse of a member or former member of the armed forces of the United States, the national guard or a reserve component
(attach a copy of your spouse's military document, for example, an ID card (DD Form 2) or Certificate of Release or Discharge from Active Duty (DD Form 214)).

5.) MEDICATION AIDE TRAINING PROGRAM INFORMATION

Name of School_____

Address_____

City_____State_____Zip_____ Telephone_____

Date of Enrollment (month/day/year) _____/_____/_____ Date of Completion (month/day/year) _____/_____/_____

Do you have at least one year of direct care experience in a residential care facility? ☐ Yes ☐ No

Are you a state tested nurse aide in Ohio? ☐ Yes ☐ No

* Your social security number is required by state and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the National Practitioner Data Bank (see 45 C.F.R. pt.60, implementing federal laws), reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state or federal law.
** If you are living in the United States, Federal Law [8 USCS § 1621] [PRWORA], limits the issuance of professional licenses to U. S. citizens or aliens lawfully admitted to the U.S

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6.) COMPLIANCE (APPLICATION WILL BE RETURNED IF ANY QUESTION IS LEFT UNANSWERED)

Please circle "Yes" or "No" for each question. Your application **is not** complete until the Board has received **ALL** required documents.

CAUTION: ***False, and/or misleading information provided by an applicant may result in the denial/permanent denial of a license/certificate.***

1.	Have you EVER been convicted of, found guilty of, pled guilty to, pled no contest to, pled not guilty by reason of insanity to, entered an Alford plea, received treatment or intervention in lieu of conviction, or been found eligible for pretrial diversion or a similar program, for any of the following crimes (this includes crimes that have been expunged IF there is a direct and substantial relationship to medication administration)? **Please answer BOTH questions a and b.**	
a.	A felony in Ohio, another state, commonwealth, territory, province, or country?	Yes No
b.	A misdemeanor in Ohio, another state, commonwealth, territory, province, or country? (This does not include traffic violations unless they are DUI/OVI)	Yes No
2.	Have you ever been found to be mentally ill or mentally incompetent by a probate court?	Yes No
If you answered "Yes" to a box above, you are required to provide the Board with a written explanation of the events including the date, county and state in which the events occurred (attach a separate sheet to this application), and a certified copy of the indictment(s) or criminal complaint(s), plea(s), journal entry(s) from the appropriate court. A copy of the court docket or case summary does not meet this requirement.		
3.	Has any board, bureau, department, agency or other body, including those in Ohio, other than this Board, in any way limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you; placed you on probation; imposed a fine, censure or reprimand against you? Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate, or registration?	Yes No
4.	Have you ever, for any reason, been denied an application, issuance, or renewal for licensure, certification, registration, or the privilege of taking an examination, in any state (including Ohio), commonwealth, territory, province, or country?	Yes No
5.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, certificate, or registration in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio, other than this Board?	Yes No
6.	Have you been notified of any current investigation of you, or have you ever been notified of any formal charges, allegations, or complaints filed against you by any board, bureau, department, agency, or other body, including those in Ohio, other than this Board, with respect to a professional license, certificate, or registration?	Yes No
If you answered "Yes" to questions 3-6, you are required to provide the Board with a written explanation and certified copies of any documents.		
7.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	Yes No
8.	Within the last five years, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	Yes No
9.	Have you, since attaining the age of eighteen or within the last five years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	Yes No
If you answered "Yes" to question 7-9 you are required to provide a written explanation, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
10.	Are you currently engaged in the illegal use of chemical substances or controlled substances? For this question "**Currently**" does not mean on the day of, or even weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a certificate holder or licensee, or within the past two years. "**Illegal** use of chemical substances or controlled substance" means the use of chemical substances or controlled substances obtained illegally (e.g. heroin, cocaine, or methamphetamine) as well as the use of controlled substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the direction of a licensed healthcare practitioner.	Yes No
a.	**If you answered "Yes" to question 10,** are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using chemical substances or controlled substances? **If you answered "Yes", you are required to provide a written explanation.** If you are participating in a monitoring program, you are required to cause the respective program to provide information detailing your participation in and compliance with the program.	Yes No N/A
11.	Have you been notified of any proceeding to determine whether you may be subject to listing on the Sexual Civil Child Abuse Registry established by the Ohio attorney general pursuant to section 3797.08 of the Revised Code, and/or are you listed on that registry?	Yes No
12.	Are you required to register, under Ohio law, the law of another state, the U.S., or a foreign country, as a sex offender?	Yes No

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_____

Last Name First Name Middle Initial

(Print clearly, your full legal name as it appears on the first page of the application)

MEDICATION AIDE AFFIDAVIT

I, _____

Full Legal Name - print

am the person in this application for Certification and the statements made herein are true and accurate.

I hereby request that in order to process my application, act upon renewal requests, and respond to public requests to confirm my certificate status, my personal information be accessed in accordance with OAC 4723-1-11 (D)(2)(d)(ii).

I have read and understand this Affidavit and consent for fingerprinting.

Legal Signature of Applicant:

_____

NOTARY

Signed and sworn before me this_____ day

of_____, 20_____.

Signature of Notary Public:

_____

Expiration Date of Commission:

_____

(NOTARY SEAL)

FOR BOARD USE ONLY

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Certificate Number	**Date Issued**
MA-C	

IN

Form A		
BCI		
FBI		
STNA		
Test Results		
Citizenship		
Compliance		
BCI/FBI Not In		

FISCAL:

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Attestation of Medication Aide Training Program Completion

Form A

Part 1-General Information-Please Print
(Applicant must complete this part and send to the medication aide training program)

Full Legal Name_____
Last First Middle Maiden

Social Security Number*_____

Telephone Number_____ Email Address_____

Signature_____Date_____

Part 2-Attestation of Completion of Medication Aide Training Program -Please Print
(Medication aide training program must complete this part and send directly to the Board)

Program Name_____

Address_____

City_____State_____Zip_____

Telephone Number of Program_____

This is to verify that the applicant named above successfully completed the above named medication aide training program on:

_____
Date of Completion (Month/Day/Year)

_____
Name of Registered Nurse Program Administrator (Print)

_____
Title of Registered Nurse Program Administrator (Print)

_____
Telephone Number of Registered Nurse Program Administrator

_____
Signature of Registered Nurse Program Administrator Date

*Your social security number is required by state law and federal law for purposes of child support enforcement (ORC 3123.50, 42 U.S.C. Section 666), reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60), reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4723.28, reporting to the National Council of State Boards of Nursing for state board investigative purposes, and/or as otherwise required by state and federal law.

Please submit this form to: Ohio Board of Nursing, Attention: Medication Aide, 17 South High Street, Suite 400, Columbus, OH 43215-7410 OR Fax to (614) 466-0388.

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