# Texarkana College
## Community & Business Education Center
## Medication Aide Course

**Spring 2019**

Extend you healthcare profession to the next level by obtaining certification as a Medication Aide for Long Term Care. This comprehensive course is designed according to the specifications for approval by the Texas Department of Aging and Disability Services. Participants will spend a total of 100 hours in classroom instruction and training, 40 hours of return skills demonstration laboratory, and 10 hours of clinical experience including clinical observation and skills demonstration under the direct supervision of a licensed nurse in a facility.

A review of training eligibility requirements, as stated on Course Information page, must be completed with the Allied Health Coordinator prior to registering for the course.

**All student registrations submitted online or in person will be "incomplete"** until a copy of the student's high school diploma or GED equivalent from the United States of America and their social security number is submitted to the Allied Health Coordinator. If the student has an "out of country" diploma they must provide a translation report verifying it is equivalent to one issued in the USA.

**Dates:** Mon. Tues. & Thurs., March 18 - June 6 | 5:00 p.m. – 9:00 p.m. | 144 hours| 12 wks.

**Student Tuition**: $650 (included textbooks)

**Location:** Health Sciences Building, Rm 141

A $25 State exam fee is due after the course begins and submitted to the State along with required student application forms listed on following documents.

**Refund Policy:** Students will receive a 100% refund upon request, 24 hours prior to the first class meeting.

## TEXARKANA COLLEGE/COMMUNITY & EDUCATION

## MEDICATION AIDE PROGRAM ELIGIBILITY APPLICATION

All students wanting to enroll in the CBE Medication Aide Program must submit a complete application (includes General Statement and Experience Report) to determine eligibility before enrolling in the program.

**GENERAL STATEMENT:**

1. Name: _____ Social Security #: _____

2. Mailing Address: _____
   City State Zip County

3. Home Telephone (with area code): _____ Date of Birth: _____

4. Are you able to read, write, speak and understand English? Yes___ No___

5. Are you at least 18 years old? Yes____ No____

6. Do you have a high school diploma, or a transcript or a GED equivalent from the United States of America?
   Yes____ No_____

7. Do you have a social security number? ____ Yes No____ If yes, please provide: _____

8. Are you, to the best of your knowledge, free of contagious diseases and in a suitable physical and emotional health to safely administer medications? Yes____ No____

9. Are you listed on the Texas Employee Misconduct Registry (EMR) as unemployable? Yes____ No____

10. Have you ever been convicted of a criminal offense listed in Texas Health & Safety Code 250.0067?
    Yes____ No____If yes, list date _____ and conviction_____

**EXPERIENCE REPORT:**

I _____ (student name) certify that I am currently employed, and will be employed on the first official day of the training program in a skilled nursing facility licensed in the state of Texas, in the capacity of a **CERTIFIED NURSE AIDE**, an Assisted Facility, a State Supported Living Center, an Intermediate Facility for the Intellectually Disabled that are licensed in the state of Texas. (Home Health Agencies & Hospitals are not Texas licensed facilities under the Medication Aide Regulations.

Or,

I _____ (student name) certify that I am currently employed, and will be employed on the first official day of this training program in either an Assisted Living Facility, a State Supported Living Center, or an Intermediate Facility for the Intellectually Disabled and licensed in the state of Texas, as a **non-licensed direct care staff (Patient Care Assistant)**. This employment has been completed within the 12-month period preceding the first official day of this class. (An applicant employed as a certified nurse aide is exempt from the 90-day requirement).

1. Name of place of employment: _____

2. How long have you been employed at the above facility. From: _____
   Month Day Year

   Until:_____
   Month Day Year

3. Address: _____
   Street No. City State Zip

4. Type of facility: _____

5. Phone Number including Area Code of facility: _____

6. Job title of applicant: _____

7. Certified Nurse Aide number (if applicable): _____ Exp. Date: _____

8. Type of work performed (be specific) _____

Please initial the following:

_____ I understand and acknowledge that I will not receive a refund if I begin the Medication Aide class and it is later determined that I have not met the application requirements as stated above.

_____ _____

Student Signature Date

_____ _____

Allied Health Coordinator Date

Approve_____ Denied_____

**Texarkana College**
**Community & Business Education**
**Medication Aide Course Information**

**Attention Registrants:**

Persons wanting to register for the Medication Aide course **must** schedule an appointment with the Allied Health Coordinator in the Community & Business Education office to complete a counseling session and application form to confirm the following training eligibility requirements are met.

1. Perspective students must submit the attached application to confirm their training eligibility requirement as stated in Texas Health & Human Services Commission , Rule $95.107(b) and must:

2. Eligibility Application Procedure to be completed and dated **AFTER THE CLASS BEGINS:**

    a. All applicants must submit the following application documents by the due date announced at the first class meeting by the Allied Health Coordinator. Any documents submitted prior to this date will not be accepted to training program.
        - **General Statement of Enrollment Form** must be signed by the applicant and notarized by appropriate notary, no sooner than the first class meeting.

        - **Experience Documentation Report Form** must be completed, signed and notarized with applicants Administrator/Program Director/DON no sooner than the first class meeting, verifying the place of employment, capacity of that employment and duration.

        - **High school diploma or GED Equivalent.** Student must be a graduate of a high school or have a general equivalency diploma;
            - An unaltered original of a high school graduation diploma or a transcript or GED diploma has to be submitted with a notarized statement and signature "This is a true and correct copy of my (transcript, or diploma or GED)".
                - The student's signature must be notarized on the copy of the above.

3. Examination Fee & Application Submission:
    a. Participants will submit their application documents on or before the date specified, to the Allied Health Coordinator for initial review, who will in turn submit those documents to the State for final review and determination of eligibility.

    b. In addition to submission of required documents for consideration, each participant will be required to submit their examination fee of $25 (which is non-refundable from the State) in the form of a cashier's check or money order made payable to the Texas Health & Human Services Commission.

4. Clinical requirement:
    a. Students will be required to complete 10 hours of clinical skills portion in a long-term care facility under the direction of a nurse.
        1) It is recommended that students complete this requirement at their place of employment by their supervising nurse.
        2) The rules and regulations require students to complete the clinical experience while they are not scheduled to work and on their own times.

Please call Joanne Rose, Allied Health Coordinator, at 903-823-3384 if you have any questions about meeting the training eligibility requirements listed above.

I acknowledge and understand the above program eligibility requirements to attend the Mediation Aide course. I also understand and acknowledge that if my application is reviewed and denied, by the Texas Health & Human Services Commission after the course begins, I will be dropped without a refund.

TEXAS HEALTH & HUMAN SERVICES COMMISSION
MEDICATION AIDE PROGRAM – MAIL CODE E416
P.O. BOX 149030
AUSTIN, TX 78714-9030
512/438-2025

## GENERAL STATEMENT ENROLLMENT FORM

All required forms must be completed and returned to the above address **NO LATER THAN 20 DAYS** after the date of the first scheduled class in which you are enrolled. Include a $25.00 NONREFUNDABLE combined application & examination fee made payable to the TEXAS HEALTH & HUMAN SERVICES COMMISSION (THHSC). If any portion of the application is incomplete, it cannot be processed.

1. NAME_____ 2. Social Security #_____

3. MAILING ADDRESS_____
Street or P.O. Box

_____
City State Zip County

4. Home Telephone (with area code)_____ 5. Date of Birth_____

6. Name of approved training School_____ City_____

7. Date of first scheduled class of instruction_____

8. Are you able to read, write, speak and understand English? Yes_____ No_____

9. Are you at least 18 years old? Yes____ No____

10. Submit an Experience Documentation Report form documenting current employment of the first official day of the training program in a facility licensed under Health and Safety Code Chapter 242 in the capacity of a **CERTIFIED NURSE AIDE** or in a Assisted Living Facility licensed under Health and Safety Code 247, State Supported Living Center, or ICF-IDD facility as a non-licensed direct care staff person. **(HOME HEALTH AGENCIES, STAFFING AGENCIES & HOSPITALS ARE NOT LICENSED FACILITIES UNDER THE MEDICATION AIDE REGULATIONS).**

11. Submit an Experience Documentation Form documenting 90 days of employment in an Assisted Living Facility licensed under Health and Safety Code Chapter 247, State Supported Living Center or ICF-IDD facility as non-licensed direct care staff.. This employment must have been completed within the 12-month period preceding the first official class date. **AN APPLICANT EMPLOYED AS A CERTIFIED NURSE AIDE IS EXEMPT FROM THE 90 DAY REQUIREMENT.**

12. Submit a certified copy or a photocopy which has been **NOTARIZED** as a true copy of an unaltered original of a high school graduation diploma or transcript or a general equivalency diploma

13. Are you, to the best of your knowledge, free of contagious diseases and in a suitable physical and emotional health to safely administer medications? Yes_____ No_____.

14. Are you listed on the Employee Misconduct Registry (EMR) as unemployable Yes___No___

15. Have you been convicted of a criminal offense listed in Texas Health & Safety Code 250.006? Yes___No____ If yes, list date_____ and conviction_____.

16. Have you received a copy of the Medication Aide Training Program Rules? Yes____No_____. If no, obtain a copy from the training program or call this office.

With few exceptions, you have the right to request and be informed about the information that THHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask THHSC to correct information that is determined to be incorrect. (Government Code Sections 552.021, 552.023, 559.004) To find out about your information and your right to request correction, please contact this office.

**PLEASE READ CAREFULLY**

In making application to THHSC Medication Aide Program for the issuance of a permit as a Medication Aide, I have read and agree to abide by the Medication Aide Training Program Rules. I also agree to complete all application requirements and take all examinations necessary for the processing of my application. Upon issuance of a permit, I agree to be bound by the Allowable and Prohibited Practices of a Permit Holder (95.105). I further understand that the materials submitted for consideration become the property of the Department and are nonrefundable. I am aware of the schedule of fees (95.109) and understand that additional fees must be paid to keep the permit current.

I further agree that if issued a permit, upon the denial, suspension or revocation of that permit, I shall return the permit to the Department.

The information that I have provided in this application is truthful. I understand that to falsify any information submitted to THHSC may result in voiding of this application and my failing to be granted a permit, or the revocation of my permit.

_____ _____
DATE SIGNATURE OF APPLICANT

THE STATE OF )

COUNTY OF )

BEFORE ME. The undersigned authority, on this day personally appeared_____
Known to me to the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledged that he/she had executed the same for the purposes and consideration therein expressed and the foregoing statements are true and correct.

Given under my hand and seal of office, this_____day of _____, _____

Notary Public in and for_____ County, Texas or _____

_____
Signature of Notary

_____
Name of Notary

_____
Commission Expiration Date

EXPERIENCE DOCUMENTATION REPORT FORM
TEXAS HEALTH & HUMAN SERVICES COMMISSION
MEDICATION AIDE PROGRAM - MAIL CODE E416
P. O. BOX 149030
AUSTIN, TX 78714-9030

APPLICANT_____SOCIAL SECURITY #_____

TRAINING SCHOOL_____

**********

Form must be filled out in its entirety by the individual certifying that the information submitted is correct.

I,_____, certify that I have employed
**(FACILITY ADMINISTRATOR/PROGRAM DIRECTOR/DON)**

_____from_____to_____ and that I know
(Applicant)
of my own knowledge that said person was employed continuously in this facility which is licensed under Health & Safety Code Chapter 242, as a certified nurse aide; or in this facility which is a licensed Personal Care Facility under Health & Safety Chapter 247, or in this State Supported Living Center, ICF-IDD as a nonlicensed direct care staff person under the direct supervision of a licensed nurse on duty or on call.

1. Place of Employment_____

2. Address_____
Street No. City State Zip

3. Phone Number including Area Code_____

4. Type of Facility_____

5. Job Title of Applicant_____

6. Nurse Aide Certificate Number (if applicable)_____
Expiration date_____

7. Type of work performed (be specific)_____

On this _____day of_____,20___, in_____,_____
I certify under penalty of perjury that the information submitted is true and correct.

_____
**SIGNATURE OF ADMINISTRATOR/PROGRAM DIRECTOR/DON**
Facility Vendor Number_____

Before me, a Notary Public in_____County, Texas on this day personally appeared_____, known to me to be the
**(ADMINISTRATOR/PROGRAM DIRECTOR/DON)**
person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____day of _____,20____

_____
(Signature of Notary)

Photocopy if additional copies are needed 9/1/17