Reset Form

QUALIFIED MEDICATION AIDE (QMA) RECORD OF ANNUAL INSERVICE TRAINING

State Form 51654 (R7 / 9-26)
INDIANA DEPARTMENT OF HEALTH – Consumer Services & Health Care Regulation

INSTRUCTIONS:

1. *Please type or print clearly in black ink.*
2. *Six (6) hours of inservice training, directly related to **medication, medication administration, and the QMA scope of practice**, must be completed for the 2-year recertification period.*
3. *For insulin administration certified QMAs, one (1) additional hour of inservice training, directly related to **insulin administration**, must also be completed for the 2-year recertification period.*
4. *Only inservices related to medication, medication administration, QMA scope of practice, and insulin administration should be included on this form.*
5. *QMA **MUST** keep the original form.*
6. *Electronic signatures are acceptable.*

Name *(Last, First, Middle Initial)*		QMA Certification Number	
Address *(number and street)*	City	State	ZIP code
Telephone *(including area code)*	E-mail address		

Date *(mm/dd/yy)*	Topic *(Medication, Medication Administration, Insulin Administration, and QMA Scope of Practice ONLY)*	Instructor Signature / Credentials *(typed name is acceptable)*	Length *(1/4 Hour Increments)*	IDOH Use Only
		TOTAL HOURS		

QMA Signature: _____ Date *(mm/dd/yy)*: _____

(typed name is acceptable)