# QUALIFIED MEDICATION AIDE (QMA) RECORD OF ANNUAL INSERVICE TRAINING

State Form 51654 (R5 / 7-21)
INDIANA DEPARTMENT OF HEALTH – DIVISION OF HEALTH CARE QUALITY & EDUCATION

*INSTRUCTIONS:*
1. *Please print or write clearly.*
2. *Six (6) hours of inservice training must be completed each year (January – December).*
3. *Only inservices related to medications, medication administration, QMA Scope of Practice, and insulin administration should be included on this form.*
4. *QMA **MUST** keep the original form.*

| 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 and QMA Scope of Practice ONLY)* | Instructor Signature / Credentials | Length *(1/4 Hour Increments)* | IDOH Use Only |
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QMA Signature: _____ Date *(mm/dd/yy)*: _____