AIDES REGISTRY CNA/QMA RENEWAL

State Form 49937 (R9 /2-24)
INDIANA DEPARTMENT OF HEALTH

INDIANA DEPARTMENT OF HEALTH
LONG TERM CARE
2 North Meridian Street, Room 4B
Indianapolis, IN 46204
Telephone: (317) 233-7442
Fax: (317) 233-7750

* Your Social Security number is requested in accordance with the provision of IC 4-1-8-1; disclosure is mandatory, and this record cannot be processed without it.

The employee must inform the Indiana Department of Health (IDOH) Aides Registry that they have worked as a Certified Nurse Aide (CNA) for eight (8) hours during a twenty-four (24) month consecutive time period.
QMA renewal requirements are as follows: 6 hours of medication related in-services education each calendar year and working administering medications at least 8 hours in the last 12 months.

***This form must be completed in its entirety by the current/previous employer only (All information is required) ***

I. AIDE CERTIFICATION

Full name of CNA/QMA		
Street address *(number and street)*		
City	State	ZIP Code
Telephone number	Date of birth *(month, day, year)*	
Social Security Number	CNA/QMA registration number	
Date of hire *(month, day, year)*	Date of termination *(month, day, year)*	
Job title	CNA/QMA expiration date *(month, day, year)*	
E-mail address		

II. CNA/QMA JOB FUNCTION

Please identify the number of hours within the last twenty-four (24) consecutive months that this individual has performed nursing-related services or administering medications (QMA).

CNA number of hours worked.	QMA number of hours administering medications

III. QMA IN-SERVICES

QMA annual medication related in-services for every calendar year, please attach & keep a copy for your personal use.

Random selections of QMA's will be notified by IDOH to submit their in-services if requested

IV. AGENCY IDENTIFICATION

Name of employer completing form			
Name of health care facility			
Facility street address *(number and street)*			
City		State	ZIP Code
Facility Number	Facility telephone number	Facility e-mail address	

I hereby attest that the above information is true and accurate.

_____ _____

Employers signature Date *(month, day, year)*