APPLICATION FOR APPROVAL TO OPERATE A QUALIFIED MEDICATION AIDE PROGRAM

State Form 47953 (R3 / 7-12)
Indiana State Department of Health - Division of Health Care Education and Quality

INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE EDUCATION AND QUALITY
2 North Meridian Street, Suite 4-B
Indianapolis, IN 46204

INSTRUCTIONS:

1. *Please complete the appropriate sections on both sides of the application.* ***All applications must be completed in Sections A and D.***
2. *Please use additional applications for more than one instructor.*
3. *Mail the completed application, along with all requested documentation, to the division at the above address.*
4. *Keep a copy of this application for your records.*

SECTION A: Training program information

PURPOSE OF APPLICATION *(check all that apply)*:

☐ Initial approval ☐ Renewal ☐ Add Instructor (Section B) ☐ Add Clinical Site (Section C)
☐ Remove Instructor – Name: ______________________________

Report change of ownership or vested partnership – Name: ______________________________
____

Name of Entity: ______________________________

Doing Business As (d/b/a): ______________________________

Street Address: ______________________________

PO Box Number: ______________________________

City: ______________________________ State: ______________

ZIP code: ______________ Telephone number: ______________ Fax number: ______________

Email address: ______________________________

Owners name: ______________________________

Owner's company name *(if applicable)*: ______________________________

Names of all officers, principles and/or vested partners: ______________________________
____
____
____

For each officer, principal and/or vested partner, specify the name and years of operation of any an all previous nurse aide training programs with which the officer, principal and/or vested partner has been or currently is associated:

____
____
____

CLASSROOM SITE *(if different from above)*:

Name:____

Address:____

City:____State:________________

ZIP code:________________________ Telephone number:_____________________

SECTION B: Program Instructor information

Name:____

Nursing License Number:_______________________

PLEASE PROVIDE SPECIFIC DATES AND LOCATIONS FOR THE FOLLOWING:

QUALIFICATIONS:

COPIES OF THE Q.M.A. TRAIN-THE-TRAINER COURSE CERTIFICATE AND R.N. LICENSE MUST ACCOMPANY THIS APPLICATION.

SECTION C: Practicum Sites

Name of Facility:____

Address:____

City:____________________________________State:_______________ZIP code:__________________

Name of Facility:____

Address:____

City:____________________________________State:_______________ZIP code:__________________

Name of Facility:____

Address:____

City:____________________________________State:_______________ZIP code:__________________

SECTION D: Certification of QMA Program

I certify that Qualified Medication Aide Program will be conducted in accordance with 412 IAC 2, the Qualified Medication Aide Basic Curriculum as developed by the Indiana State Department of Health, and any other standards for Qualified Medication Aide programs established by the Indiana State Department of Health. I certify that adequate records will be maintained and made available to ISDH surveyors in order to determine compliance with those standards. I certify that the administrator of this program as well as other personnel (including owners, officers, principals and vested partners) have never been subject to a revocation of approval of a Qualified Medication Aide program.

______________________________	______________
Administrator of facility OR Director of non-facility based program	Date *(month, day, year)*