



APPLICATION FOR APPROVAL OF THE QUALIFIED MEDICATION AIDE COURSE

State Form 51118 (10-02)

Indiana State Department of Health – Division of Long Term Care

INSTRUCTIONS: Please complete the appropriate sections on both sides of the application. **All applications must be completed in Sections A and D.**

SECTION A: Training program information

APPLICATION PURPOSE (check all that apply):

- ☐ Initial approval; ☐ Renewal; ☐ Add Instructor (Section B); ☐ Add Clinical Site (Section C);
☐ Remove Instructor: Name _____

Name of Facility: _____

Street Address: _____

PO BOX #: _____

City: _____ State _____

ZIP: _____ Phone number: _____ Fax number: _____

SECTION B: Program Instructor information

Name: _____

Nursing License #: _____ Vocational License #: _____

A copy of the license MUST accompany this application

PLEASE PROVIDE SPECIFIC DATES & LOCATIONS FOR THE FOLLOWING:

QUALIFICATIONS:

***A COPY OF THE Q.M.A. TRAIN-THE-TRAINER COURSE CERTIFICATE MUST
ACCOMPANY THIS APPLICATION***

SECTION C: Practicum Sites

Name of Facility: _____

Address: _____ City _____

Name of Facility: _____

Address: _____ City _____

Name of Facility: _____

Address: _____ City _____

SECTION D: Certification of QMA Program

I certify the above information is correct and the named facility/school in Section A will abide by the criteria set forth by 412 IAC 2.

Administrator of facility OR Director of non-facility based program

Date

Mail completed application, along with requested documentation to:

INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE
2 N. MERIDIAN ST., 4B
INDIANAPOLIS, IN 46204

Please use additional applications for more than one director. Also, keep a copy of this application for your records.