Department of Health & Human Services
Division of Public Health, Licensure Unit
Office of Nursing & Nursing Support
PO Box 94986
Lincoln NE 68509-4986
Phone: (402) 471-4322

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Application for Medication Aide Registration

Reminder: Include a check/money order for the $18 non-refundable registration fee.
Make payable to DHHS Licensure Unit.

Section 1: Personal Information

(Please note that in order to change a name that is already on our system, we must have documentation of proof of name change.)

Name ____
Last First Middle Maiden Previously used names

Address: ____
Street Apt# City State Zip code

Telephone number: Home ____________________ Cell ____________________

Email Address (required): ____

Date of birth: __________ Place of birth: ______________ (city/state) Social Security Number: ______________

Section 2: Background

Have you been convicted of a crime other than speeding? ☐ Yes ☐ No

If you answered YES, you MUST list the date of conviction, county/state in which the conviction occurred and the type of conviction(s). (Attach additional sheet(s) of paper if necessary to list crimes/convictions.) On an additional sheet of paper, please include a brief description of the conviction including what the conviction was for, what happened and who was involved. You **must** submit copies of the following information for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. *****Please note that a conviction is not necessarily a disqualification for placement on the Registry.*

Date of Conviction	County/State	Type of Conviction

Have you provided medications without being active on the Medication Aide Registry? ☐ Yes ☐ No

If you answered yes, how many partial or whole days did you provide medications? __________
Please explain why you have been providing medication without being registered as a Medication Aide ______________
____

Section 3: Applicant's Attestation of Lawful Presence in the United States:

For the purpose of complying with Nebraska Revised Statutes §4-108 through §4-114, I attest as follows:

Please check the appropriate choice below:

_____ I am a citizen of the United States

_____ I am a qualified alien under the Federal Immigration and Nationality Act. My Immigration status is ___________________________ and alien/USCIS number is _______-_______-_______. Please provide a copy of your United States Citizenship and Immigration Services documentation.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Section 4: Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name of Applicant: ____________________________________

Applicant's Signature: ____________________________________ Date: ____________________

The following section is to be completed by the Licensed Health Care Professional conducting your competency assessment and/or directing a registered Medication Aide to conduct the competency assessment and/or the 40-hour course completion, if applicable.

Section 5: Documentation of Competency Assessment

This is to certify that ____ has successfully demonstrated competency in the following areas: (Print Medication Aide Applicant's Name)

Demonstrated the ten (10) competencies as identified in Nebraska Revised Statute §71-6725

1. Maintaining confidentiality,
2. Complying with a recipient's right to refuse to take medications,
3. Maintaining hygiene and current accepted standards for infection control,
4. Documenting accurately and completely,
5. Providing medications according to the five rights,
6. Having the ability to understand and follow instructions,
7. Practicing safety in application of medication procedures,
8. Complying with limitations and conditions under which a medication aide may provide medications,
9. Having an awareness of abuse and neglect reporting requirements, and
10. Complying with every recipient's right to be free from physical and verbal abuse, neglect, and misappropriation or misuse of property.

Demonstrated providing routine medications by the routes identified in Title 172, NAC 95-005.01

1. Oral (mouth, sublingual, buccal, sprays),
2. Inhalation (inhalers, nebulizers, oxygen),
3. Topical (sprays, creams, ointments, lotions, transdermal patches), and
4. Instillation (drops, ointments, and sprays in eyes, ears, and nose)

Signature of Licensed Health Care Professional	Profession	Professional License #	Date competency completed

Place of employment of Licensed Health Care Professional	Telephone number

If the competency assessment was conducted by a registered Medication Aide, the following information must be provided:

Signature of registered Medication Aide conducting the competency assessment	Registry #	Date

Place of employment of Medication Aide conducting the competency assessment	Telephone number

Medication Aide 40-Hour Course Completion – According to Nebraska Revised Statute §71-6725(4) to work in assisted living facility, a nursing home, or an intermediate care facility for persons with developmental disabilities, the applicant must have completed a 40-hour course. Please complete the following as documentation of course completion if the applicant wishes to be authorized to work in these settings.

Name of College or Facility Providing the Training Program	Date of Completion

Instructor's Signature	Profession and License Number

Revised May 2014