NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

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

Reapplication 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: _____ Social Security Number: _____
(city/state)

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 upon request.

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.

Revised May 2014

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 the competency assessment and/or directing a registered Medication Aide to conduct the competency assessment.

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

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