**MEDICATION AIDE CHLT-4000 56 Contact Hours**

**HAND IN TO INSTRUCTOR FIRST SESSION**

**Candidate—Please Print**

1. **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **K # or SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Student’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **Telephone (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( ©)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sponsoring Facility – Please print**

1. **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
4. **Administrator’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
5. **Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Directions: Dear Facility Administrator, please (10 Select the type of facility from the choices below and (2) Answer all questions under that section. Please have student bring to first class session.**

**I. Certified Nursing Facility:** By signing, the facility recommends applicant based on responses 1-6.

1. Nursing Facility Recommends applicant for Medication Course. Yes\_\_\_\_\_ No\_\_\_\_\_
2. Nursing Facility agrees to sponsor/recommend applicant. Yse\_\_\_\_\_No\_\_\_\_\_
3. Verify to the best of your knowledge the individual is free from drug/alcohol abuse Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_
4. All applicants must be employed for at least six (6) months by facility sponsor. Date of Hire \_\_\_\_
5. The applicant must be on the DCW Registry (formally: State Nurse Aide Registry/Certified Nurse Aide): DCW Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. The facility’s RN will supervise and provide written documentation of the clinical work site. Yes\_\_\_\_\_\_ No\_\_\_\_\_\_
7. Please Print name of supervising RN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Nursing Facility Administrator, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**II. Residential or related type of licensed facility:** By signing, the facility recommends applicant based on responses 1-6.

1. Residential facility recommends applicant for Medication course. Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_
2. Residential facility agrees to sponsor /recommend applicant. Yes\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_
3. Verify to the best of your knowledge the individual is free from drug/alcohol abuse Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_
4. The facility’s RN will supervise and provide written documentation of the clinical at the work site? Yes\_\_\_\_\_ No\_\_\_\_\_\_
5. Please print the name of supervising RN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature Nursing Facility Administrator, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**III. Assisted Living program:** By signing, the facility recommends based on 1-5.

1. Assisted living facility recommends applicant for Medication course. Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Assisted living facility agrees to sponsor/recommend applicant. Yes\_\_\_\_\_\_\_\_\_\_ ­ No\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Verify to the best of your knowledge the individual is free from drug/alcohol abuse Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_
4. The facility’s RN will supervise and provide written documentation of the clinical at work site. Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_.
5. Please print the name of supervising RN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Nursing Facility Administrator, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_.**

**IV. If applicants work in more than one type of facility, the higher requirement is recommended to allow applicant to work in multiple assignment areas.**

**\*\*\*Successful Completion: Both portions of the course, classroom and clinical, must be completed within 30 days of class end date. At that time a State Exam will be given. Upon successful completion of the course and State exam the candidate will receive a certificate from Kirkwood Community College. Candidate has up to 6 months post class start date to complete state testing.**

**KCC Continuing Education 6301 Kirkwood Blvd. SW Cedar Rapids, IA 52406**