FEES ARE NON REFUNDABLE

1701 001 - $ 500.00

Department of Health
Division of Health Licensure and Regulation
Tennessee Board of Nursing
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

Application for a Medication Aide Training Program

Submit application at least 90 days prior to board meeting

Name of Qualified Entity (name of program): _____

Address of Qualified Entity: _____ _____ _____
(Street) (City/State/Zip)

Address of Training Program: _____
(Street) (City/State/Zip)

Website address of training program: _____

Name of Program Director:_____

Email address: _____ Phone number: _____

Director and Instructor Information

Name	RN/LPN State and License # e.g. TN RN 12345	Exp. Date	Nursing Education Institution/Degree	Teaching/Nursing Years of Experience *Attach Resume/CV	I attest to verifying that those listed have at least one year nursing and medication administration experience in long term care.
Director:				Teaching _____ Nursing _____	Yes _____ No _____
Instructor:				Teaching _____ Nursing _____	Yes _____ No _____
Instructor:				Teaching _____ Nursing _____	Yes _____ No _____

Submit the following as directed:

- Program organizational chart
- Name and address of clinical facilities
- Financial support and resources adequate to teach students the curriculum
    - Budget
    - Photos of classroom/lab, equipment, other
    - List of supplies
    - Qualified administrative, instructional and support personnel and services
- Curriculum
    - Topic outlines (list summarized topics covered in each course)
    - Clock hours for didactic and clinical
- Policies
    - Catalog/brochure
    - Admissions
    - Progression
    - Grading system for didactic and clinical
    - Evaluation of student performance that includes at least one written evaluation during the first half of the program
    - Dismissal of students
    - Completion
    - Transcripts (upon request, completion, withdrawal)
    - Program evaluation (feedback from instructors, students, employers)
    - Maintenance of attendee records of each course (minimum 6 years following date of enrollment)
    - Certification requirements

I, being duly sworn and identified as the person completing this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the training and practice of medication aides and nursing, which are posted on the Board's internet site and/or were provided to me by the Board office, and agree to abide by them.

I HEREBY:
SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.
RELEASE to the Board, its staff, and their representatives, any and all program documentation necessary now and in the future.
RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for program certification.
ACKNOWLEDGE that I, as an applicant on behalf of the medication aide program requesting approval, have the burden of producing adequate information for a proper evaluation of the program's qualifications.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____

Signature Date