Health Certification Project
TRAINING VERIFICATION FORM – Certified Medication Aide

CANDIDATE INFORMATION
Name ___________________________ Social Security Number ___________________________

TRAINING INFORMATION
Training Facility Name: ______________________________________________________________
Training Facility Address: ___________________________________________________________
Training Completion Date: ___________ Training Facility Code: __________________________
Instructor’s Name (Please print clearly) ________________________________________________
Instructor’s Signature _______________________________________________________________

TRAINING VERIFICATION STATEMENT
I verify that the above named candidate has successfully completed the minimum number of training hours and that this training was provided through a program approved by the Oklahoma State Department of Health. I also attest that, after training was completed, the above named candidate passed medications to 20 consecutive individuals without error and that documentation of these medication passes has been retained in his/her training file.

RN | LPN | Other

Training Supervisor’s Name (Please print clearly) ______________________________________
Training Supervisor’s Signature ______________________________________________________
Training Supervisor’s Telephone Number _______________________________________________
Date ___________ 

CERTIFIED MEDICATION AIDE STATEMENT OF ATTESTATION
I, ________________________, attest that I meet all of the following requirements for certification as a medication aide (please initial each in the blank provided):

_____ I am at least eighteen years of age. _____ I have high school diploma or G.E.D.
_____ I have a current Oklahoma nurse aide certification with no abuse notations. _____ I have at least six months experience working as a certified nurse aide.
_____ I have the physical and mental capability to perform the duties of a CMA. _____ I passed medications to 20 consecutive individuals without error after completing the training program above.

Candidate Signature __________________________________ Date of Signature ___________
Candidate Name (printed) __________________________________________________________

WRITTEN COMPETENCY EXAMINATION RECORD
The Test Site Coordinator must sign and date this form at each written competency test administration. Candidates that do not pass the written competency examination after three attempts must retrain and repeat the testing process.

Written Exam 1 ___________________________________________ Date ___________ Pass/Fail
Test Site Coordinator Signature ______________________________
Written Exam 2 ___________________________________________ Date ___________ Pass/Fail
Test Site Coordinator Signature ______________________________
Written Exam 3 ___________________________________________ Date ___________ Pass/Fail
Test Site Coordinator Signature ______________________________

NOTE: All testing must be completed within three years of completion of training.
Revised July 9, 2018