



Application for Advanced Training Certificate

Certified Medication Aide – Diabetes Care

Glucose Monitoring and Insulin

TRAINEE INFORMATION

(Printed) Trainee Name: _____ Social Security #: _____

Address: _____

City, State & Zip: _____ Phone: (_____) _____

I completed the CMA Advanced Training Program Diabetes Care. I request to have this additional training noted on the Oklahoma Nurse Aide Registry.

Signature of Trainee: _____ Date: _____

TRAINING INFORMATION

NOTE: CMA's are eligible to perform only the task of Blood Glucose Monitoring after completion of the 6 hour classroom program and 2 hours of supervised practical training.

Please enter the number of training hours completed.

_____ Training on care of diabetes – Glucose Monitoring Hours

A minimum of six hours of classroom training and two hours of supervised practical training

_____ Training on care of diabetes – Glucose Monitoring and Insulin Administration Hours

A minimum of twelve hours of classroom training and a minimum of four hours of supervised practical training.

Training Instructor's Name: _____ Phone (_____) _____

Training Program Code: _____ Training Program Name: _____

Training Program Address: _____

INFORMAL TESTING AND SKILL PROFICIENCY RECORD

Skill proficiency of 100% accuracy -Date _____ Administered by: _____

Written test of 90% accuracy – Date _____ Administered by: _____

TRAINING VERIFICATION STATEMENT

I verify that the above named CMA Trainee has completed the GM and IA training program indicated on this form on the date identified and that the training program has been **approved by the Oklahoma State Dept. of Health**. I have also verified that the above named CMA Trainee has satisfied the state requirements for skills proficiency and written tests administered during training.

Date Trainee Started Training: _____ Completed Training: _____

RN Supervisor Signature: _____ Date: _____

RN Supervisor's Tel #: (_____) _____

WRITTEN CERTIFICATION EXAMINATION RECORD – INSULIN ADMINISTRATION

		Candidate Scored 80% or higher?	
Exam Date: _____	Test Proctored By: _____	Y	N
Exam Date: _____	Test Proctored By: _____	Y	N
Exam Date: _____	Test Proctored By: _____	Y	N

CHECK APPLICABLE BOX:

_____ Trainee **PASSED** Insulin Administration written certification exam and has demonstrated competency for both insulin administration and glucose monitoring.

_____ Trainee **FAILED** Insulin Administration written certification exam, and has only demonstrated competency for glucose monitoring.

In order to be listed on the Oklahoma Nurse Aide Registry and receive a certification card, the Trainee must submit this completed form with a \$10 non-refundable certification fee to the mailing address above.