Nurse Aide Registry
Oklahoma State Department of Health

Application for Advanced Training Certificate
Certified Medication Aide – Diabetes Care
Glucose Monitoring/Insulin Administration

Nurse Aide Registry
P. O. Box 268816
Oklahoma City, OK 73126-8816
Phone (405) 271-4085
Toll Free (800) 695-2157

TRAINEE INFORMATION

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

Address: _____

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

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

Trainee Signature: _____ 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/Signature: _____ 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/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 Name: _____ Date: _____

RN Supervisor Signature: _____ RN Supervisor's Phone #: ( ) _____

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.