OKLAHOMA State Department of Health

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

Nurse Aide Registry
PO Box 268816
Oklahoma City, OK 73126-8816
Ph. 405-426-8150

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/E-mail: _____ **Date:** _____

TRAINING INFORMATION

NOTE: If the training program is approved for insulin administration, they cannot choose to teach glucose monitoring only. Approved insulin administration programs must teach glucose monitoring and insulin administration.

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 or 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/E-mail: _____ **Date:** _____

RN Supervisor Signature: _____ **Phone #:** (____)_____

WRITTEN CERTIFICATION EXAMINATION RECORD – INSULIN ADMINISTRATION

Candidate Must Score at Least an 80%

Exam Date: _____ **Test Proctored By:** _____ **Pass** **Fail**

Exam Date: _____ **Test Proctored By:** _____ **Pass** **Fail**

Exam Date: _____ **Test Proctored By:** _____ **Pass** **Fail**

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.