

**Certified Medication Aide Retest Application OAC 310:677-1-3(g)**

**Section 1 – Certified Medication Aide Retest**  
 \*\*If your CMA certification has been expired for more than one (1) year you must retest. If you have been expired for three (3) years or longer you must retrain.\*\*

**CMA Retest - \$15 Fee Required Original Expiration Date:** \_\_\_\_\_

**Reason for Retesting**

Expired over one (1) year, but no more than three (3) years.

Did not take Continuing Education Update class before expiration or within one (1) year of expiration (OAC 310:677(b)(4))

**You are a nurse aide currently certified in (please select ALL appropriate certification(s)):**

LTC – Expiration Date: \_\_\_\_\_  HHA – Expiration Date: \_\_\_\_\_  DDCA – Expiration Date: \_\_\_\_\_

**Section 2 - Personal Information**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
First MI Last

\*\*If you have had a **name change** since your last renewal, please include a certified copy of the marriage license or other court document which reflects the change of name when you submit this application.\*\*

\_\_\_\_\_  
Current Mailing Address City State Zip

\_\_\_\_\_  
E-mail address Telephone Number

**\*If this application is approved, you will receive an approval letter to take the written and skills exams at the testing facility of your choice. The original letter MUST be presented to the testing site before you will be authorized to take the examinations. Duplicate retest approval letter will not be reissued.\***

\*\*Upon completion of your test the testing entity has 30 days to submit testing results to the Nurse Aide Registry, at which time you will be added to the database. You may verify your certification status online at [nar.health.ok.gov](http://nar.health.ok.gov)\*\*

If you have any questions, please call our office at (405) 426-8150 or by email at [nar@health.ok.gov](mailto:nar@health.ok.gov).

**Section 3 - Attestation for CMA Retest**

Please verify that the information provided is correct. The Oklahoma State Department of Health may deny, suspend, withdraw &/OR not renew the certification of a medication aide who intentionally provides false or misleading information to a training program, a facility or the Oklahoma State Department of Health.

Yes  No I am a minimum of 18 years of age.

Yes  No I have a minimum education of high school or general equivalency diploma.

Yes  No I have a current Oklahoma LTC, HHA &/OR DDCA nurse aide certification with no substantiated abuse notations.

Yes  No I have the physical and mental capability to safely perform the duties of a nurse aide.

**Section 4 – Affirmation**  
 I affirm the information on this form to be true and correct to the best of my knowledge.

**X** \_\_\_\_\_ / \_\_\_/\_\_\_ \_\_\_\_\_  
 Signature of Nurse Aide Date Name of most recent Facility/Agency where employed – Phone

Make check/money order payable to: **OSDH/Nurse Aide Registry**  
 Mail to: **NAR-OSDH, PO Box 268816, Oklahoma City, OK 73102**

**NOTE: \*All fees submitted are NON Refundable** Total Enclosed \$ \_\_\_\_\_