Nurse Aide Registry
Oklahoma State Department of Health

**Nurse Aide Registry**
PO Box 268816
Oklahoma City, OK 73126
Tel. (405) 271-4085

# NURSE AIDE EMERGENGY RULE

## TRAINING EXCEPTION APPLICATION (limited to Emergency Rule only)

**(**h) Unlicensed health professionals under this section seeking certification may, at any time, but not later than 120 days following the lifting of the declaration of emergency, submit a training exception request and sit for the competency examination pursuant to OAC 310:677-1-3(c).

Please check the type of certification you are requesting. If approved, you are eligible to test for placement on the Nurse Aide Registry. (To test for CMA, you must be currently certified as a LTCA, HHA, or DDDCA, and meet the eligibility requirements. Please sign the appropriate Affirmation, which is attached.)

- ☐ LTC = Long Term Care Aide **(No Fee Required)**
- ☐ ADC = Adult Day Care Aide **$15 fee**
- ☐ HHA = Home Health Aide **$15 fee**
- ☐ RCA = Residential Care Aide **$15 fee**
- ☐ DDDCA = Developmentally Disabled Direct Care Aide **$15 fee**
- ☐ CMA = Certified Medication Aide **$15 fee**

**Please include the following:**

- ☐ **LTC ONLY** – Skills Performance Checklist, Affirmation of 16 hours of Training, and 10 hours of Alzheimer's disease training
- ☐ **CMA ONLY** (*Must first have LTC, HHA, or DDCA*) – Medication Skills Performance Checklist (Signed & Dated) and Medication Pass Worksheet
- ☐ **HHA, DDCA, ADC, and RCA** – Skills Performance Checklist (Signed & Dated) and documentation of any additional training (i.e. Alzheimer's disease Training, Oklahoma Core Curriculum, etc.)
- ☐ A **Non-Refundable** $15.00 processing fee for HHA, DDDCA, ADCA, RCA, and CMA **OAC 310:677-1-3(f)(3)**

Name (Please Print): _____ SSN: _____/____/_____ Date of Birth: _____

Address:_____
City State Zip

Signature:_____ Date:_____

E-mail Address:_____

## Affirmation

To be eligible to test for a training exception for placement on the Oklahoma Nurse Aide Registry as a Medication Aide, you must have a current nurse aide certification in Long Term Care Nurse, Home Health, and/or Developmentally Disabled Direct Care.

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

**X_____ ___/___/___**

**Signature of Nurse Aide Date**

***Please attach this completed form with the requested documents and the $15.00 Non-refundable processing fee (No fee for LTC), and mail to the Oklahoma State Health Department at the above address.**

(4/30/20)
Draft

# Affirmation of Required Sixteen (16) Hours of Training

This form is the nurse aide trainee's and instructor's affirmation the trainee has met the required 16 hours before direct contact with residents.

(a) The training program shall include

(2) At least sixteen (16) hours of training in the following areas prior to any direct contact with a resident that is documented and signed by the nurse aide trainee.

(A) Communication and interpersonal skills.
(B) Infection control.
(C) Safety and emergency procedures, including the Heimlich maneuver.
(D) Promoting resident's independence.
(E) Respecting a resident's rights.

**Please indicate the number of hours that the trainee has received in the following areas to verify the 16 hours of required training:**

| | |
|---|---|
| | Communication and Interpersonal Skills |
| | Infection Control |
| | Safety/Emergency Procedures, Including the Heimlich Maneuver |

| | |
|---|---|
| | Promoting Residents' Independence |
| | Respecting Residents' Rights |

***The trainee and instructor affirm the trainee has received at least 16 hours of training (total) in the above areas prior to any direct contact with residents.***

SIGNATURE OF TRAINEE _____ DATE _____ PRINTED NAME OF TRAINEE _____

SIGNATURE OF INSTRUCTOR _____ DATE _____ PRINTED NAME OF INSTRUCTOR _____

NAME OF FACILITY _____

Protective Health Services
Oklahoma State Department of Health

# SKILLS PERFORMANCE CHECKLIST

Nurse Aide Registry (NAR)
Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73117-1207
Ph: (405) 271-4085 * Toll Free: (800) 695-2157

**Facility Name:** **City, Town:**

**Student/Trainee Printed Name:**

**Student/Trainee Signature:** **Trainee Initials:**

**Instructor Printed Name:** **License #**

**Instructor Signature:** **Instructor Initials:**

**Instructor Printed Name:** **License #**

**Instructor Signature:** **Instructor Initials:**

**Instructor Printed Name:** **License #**

**Instructor Signature:** **Instructor Initials:**

**Instructor Printed Name:** **License #**

**Instructor Signature:** **Instructor Initials:**

| SKILLS: INFECTION CONTROL | Date Satisfactorily Performed | Student Trainee Initials | Instructor Initials |
|---|---|---|---|
| Perform Hand washing/use of Hand Sanitizer | | | |
| Perform Heimlich maneuver | | | |
| Seizures | | | |
| Falling and Fainting | | | |
| Apply personal protective equipment (gloves, mask and gown) | | | |
| Remove personal protective equipment (gloves, mask, and gown)/hand sanitizer | | | |
| Handle soiled linens | | | |
| Double-bag for isolation precautions | | | |
| Apply/Remove waist restraint/lap buddy | | | |
| Apply/Remove ankle/wrist restraint | | | |
| Apply/Remove vest restraint | | | |

| SKILLS: MEAL/FEEDING | | | |
|---|---|---|---|
| Use proper feeding techniques/Hygiene for resident | | | |
| Provide partial feeding assistance | | | |
| Use positioning and adaptive feeding devices | | | |
| Measure/Record Fluid Intake | | | |
| Measure/Record Solid Intake | | | |

Protective Health Services
Oklahoma State Department of Health

# SKILLS PERFORMANCE CHECKLIST

| SKILLS: PERSONAL CARE | Date Satisfactorily Performed | Student Trainee Initials | Instructor Initials |
|---|---|---|---|
| Provide male perineal care | | | |
| Provide female perineal care | | | |
| Provide oral care | | | |
| Provide oral care for unconscious resident | | | |
| Provide denture care | | | |
| Provide hair care | | | |
| Shave the resident | | | |
| Provide nail care to non-diabetics | | | |
| Provide foot care to non-diabetics | | | |
| Provide skin checks/Heel and elbow protectors | | | |
| Provide dressing/undressing assistance | | | |
| Apply compression support stockings | | | |
| Make unoccupied bed | | | |
| Make occupied bed | | | |
| Provide tub, whirlpool, or shower assistance | | | |
| Provide complete bed bath | | | |
| Provide backrub | | | |

| SKILLS: ELIMINATION | | | |
|---|---|---|---|
| Provide bedpan/fracture pan assistance | | | |
| Provide urinal assistance | | | |
| Provide bedside commode assistance | | | |
| Provide bathroom commode assistance | | | |
| Provide indwelling catheter care | | | |
| Measure/record fluid output | | | |

| SKILLS: VITAL SIGNS | | | |
|---|---|---|---|
| Perform/record manual and digital blood pressure | | | |
| Measure/record manual and digital pulse | | | |
| Measure/record pain | | | |
| Measure/record respirations | | | |
| Measure/record temperature with glass or digital thermometers | | | |
| Measure/record height | | | |
| Measure/record weight | | | |

| SKILLS: POSITIONING | | | |
|---|---|---|---|
| Perform active range of motion exercises | | | |
| Perform passive range of motion exercises | | | |
| Position resident fowlers | | | |
| Position resident lateral | | | |
| Position/reposition resident in chair | | | |
| Use prosthetic, orthotic, and assistive positioning devices | | | |

Protective Health Services
Oklahoma State Department of Health

# SKILLS PERFORMANCE CHECKLIST

| SKILLS: AMBULATION | Date Satisfactorily Performed | Student Trainee Initials | Instructor Initials |
|---|---|---|---|
| Use a gait/transfer belt | | | |
| Assist resident with walker/rolling walker | | | |
| Assist resident with walking | | | |

| SKILLS: LIFTING AND TRANSFER | | | |
|---|---|---|---|
| Use a mechanical lift | | | |
| Use a gait/transfer belt | | | |
| Use a lift sheet | | | |
| Perform slide board transfer | | | |
| Move resident up/down in bed | | | |
| Move resident side/side in bed | | | |
| Turn resident onto side | | | |
| Logroll resident | | | |
| Perform standing pivot transfer | | | |
| Perform 2-person, head-to-foot lift | | | |
| Perform 2 -person, side-to-side lift | | | |
| Assist resident to sit on the side of the bed | | | |
| Transfer resident to wheelchair/operation of wheelchair | | | |
| Transfer resident to bedside commode | | | |
| Transfer resident to chair/geriatric recliner | | | |

## SKILLS PROFICIENCY COMPLETION STATEMENT

***I verify that the skills performance checklist has been completed in accordance with safe guidelines set forth. I further affirm the above named trainee/employee has satisfactorily performed all skills on the skills performance checklist and has been determined proficient in those skills.***

Instructor/Nurse Supervisor Signature: _____ Date:_____

Student Trainee Signature:_____ Date:_____

*Per 310:677-3-4, Trainees shall not perform services for which they have not been trained and found proficient by the instructor.*

# Alzheimer's Disease Training

# Affirmation of Required Ten (10) Hours of Training

This form is the nurse aide trainee's and instructor's affirmation the trainee has met the required qualifications in Oklahoma Administrative Code (OAC) 310:677-11-4(c) as required by Title 63 of the Oklahoma Statutes (O.S.), § 1-1951(A)(3).

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**In Accordance with OAC 310:677-11-4(c):**

(c) Pursuant to 63 O.S. 1-1951(A)(3), the long term care aide training program shall *include a minimum of ten (10) hours of training in the care of Alzheimer's patients.*

**Title 63 of the Oklahoma Statutes, § 1-1951(A)(3)** requires the following:
*The State Department of Health shall have the power and duty to determine curricula and standards for training and competency programs. The Department shall require such training to include a minimum of ten (10) hours of training in the care of Alzheimer's patients.*

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***The trainee and instructor affirm the trainee has received at least 10 hours of training in caring for individuals living with Alzheimer's Disease.***

SIGNATURE OF TRAINEE _____ DATE _____ PRINTED NAME OF TRAINEE _____

SIGNATURE OF INSTRUCTOR _____ DATE _____ PRINTED NAME OF INSTRUCTOR _____

NAME OF TRAINING PROGRAM _____