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